Child Abuse and Neglect Handbook for Montana Legislators December, 1978

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CHILD ABUSE AND NEGLECT HANDBOOK FOR MONTANA LEGISLATORS

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Prepared by
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MONTANA LEGISLATORS'S HANDBOOK ON CHILD ABUSE AND NEGLECT

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SECTION I: WHAT IS CHILD ABUSE AND NEGLECT?

DEFINITIONS

1. PHYSICAL ABUSE is the most commonly recognized form of abuse. It refers to the act, or failure to act, by a parent or caretaker that causes some physical injury or some impairment of future growth and development of the child. Many state laws also use the term "any non-accidental physical injury" in this context.

2. SEXUAL ABUSE is a type of physical abuse and ranges from molestation which includes fondling, exposure and masturbation, to intercourse which includes incest and rape.

    a. "Sexual abuse" includes rape, incest, prostitution, and molestation, as defined by State law.
    b. "Sexual exploitation" includes prostitution and the obscene or pornographic photographing, filming, or depicting of children for commercial purposes.

3. EMOTIONAL ABUSE OR NEGLECT referred to as "mental injury" under Montana law, is difficult to define and prove. It would include "the parent's lack of love and proper direction, inability to accept a child with his potentialities as well as his limitations...(and) failure to encourage the child's normal development by assurance of love and acceptance". For example, a parent who constantly verbally downgrades a child may be guilty of emotional abuse. The parent who consistently ignores a child might be guilty of emotional neglect.

4. INSTITUTIONAL ABUSE refers to acts or the lack of action occurring in institutional settings which fail to provide children with the material and emotional support needed for their development. "Such acts or (lack of action) may originate with an individual employee of an institution, e.g., a teacher, a child care worker, a judge . . . or a social worker . . . ." These acts may also be part of the standard practice of an agency or institution. Examples might include inappropriate disciplinary measures, such as long periods in solitary confinement or withholding of food, as well as harsh physical punishment.

5. SOCIETAL ABUSE originates in acts or inactions of our society as a whole which may be detrimental to the growth of children. Examples might include the minimal assistance provided to millions of poverty children who are "inadequately nourished, clothed, housed, and educated". Other examples would include racism, sexism, or governmental inaction which does not insure that the health and welfare of children are protected.

6. PHYSICAL NEGLECT refers to the failure to provide adequate food, clothing, medical attention, shelter, care and supervision and protection. Not providing an opportunity for mandatory education as defined by state law could also be included.

7. CHILD means a person under the age of eighteen, or the age specified by the child protection law of the State.

8. HARM to a child's health or welfare means physical or mental injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment. "Threatened harm" means a substantial risk of harm.

9. A PERSON RESPONSIBLE FOR A CHILD'S WELFARE includes the child's parent; guardian; foster parent; an employee of a public or private residential home, institution or agency; or other person legally responsible, under State law, for the child's welfare in a residential setting.

10. A PROPERLY CONSTITUTED AUTHORITY is an agency with the legal power and responsibility to perform an investigation and take necessary ameliorative and protective steps to prevent and treat child abuse and neglect. A properly constituted authority may include the police, the juvenile court or any agency thereof, or a legally mandated, public or private child protective agency.

11. CHILD PROTECTION SERVICES or PROTECTIVE SERVICES are services usually performed by social service workers to alleviate neglect or abuse.

12. CHILDREN IN NEED OF PROTECTION under the Montana Youth Court Act refers to dependent, neglected, or abused children.

13. CHILDREN IN NEED OF SUPERVISION under the Montana Youth Court Act refers to delinquent or incorrigible children.

SECTION II: WHAT IS THE LAW?

Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act".

Child Abuse Prevention and Treatment Act.
88 STAT. 4

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

88 STAT. 5
Establishment.

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall—

Annual research summary.

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect;

Information clearinghouse.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect;

(3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

Study.

(6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

Amended January 3, 1975 by P.L. 93-644.

(c) The Secretary may carry out his functions under subsection (b) of this section either directly or by way of grant or contract.*

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be— Grants and contracts.

(1) for the development and establishment of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect; 88 STAT. 6

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel which are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Not less than 50 per centum of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.

(b) (1) Of the sums appropriated under this Act for any fiscal year, not less than 5 per centum and not more than 20 per centum may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs. Grants to States.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting;

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians; 88 STAT. 7

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and appropriate State agencies providing human services;

(G) provide that in every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;

(H) provide that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects;

(I) provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect; and

(J) to the extent feasible, insure that parental organizations combating child abuse and neglect receive preferential treatment.

(3) Programs or projects related to child abuse and neglect assisted under part A or B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), and (F) of paragraph (2). 49 Stat. 627; 81 Stat. 911. 42 USC 601, 620.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.

(e) For the purposes of this section, the term "State" includes each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, the Virgin Island, Guam and the Trust Territories of the Pacific.* Amended January 3, 1975 by P.L. 93-644.

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purposes of this Act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, and $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal year.

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the date of enactment of this Act, appoint an Advisory Board on Child Abuse and Neglect (hereinafter referred to as the "Advisory Board"), which shall be composed of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.

Membership.

Functions.

(b) The Advisory Board shall prepare and submit, within eighteen months after the date of enactment of this Act, to the President and to the Congress a report on the programs assisted under this Act and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.

Report to President and Congress.

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or $1,000,000, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

*Amendments Section 2(c) and Section 4(e) added by P.L. 93-644, approved January 3, 1975.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 93-685 (Comm. on Education and Labor).
SENATE REPORT No. 93-308 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
July 14, considered and passed Senate.
Dec. 3, considered and passed House, amended.
Dec. 20, Senate agreed to House amendments with amendments.
Dec. 21, House concurred in Senate amendments.

SUMMARY OF PROPOSED LEGAL CHANGES

The following sections of Montana law relate to abused, neglected, and dependent children or youth. A summary of proposed changes in these sections appears in the following pages.

SUMMARY OF PROPOSED LEGAL CHANGES

Old Law	Proposed Changes
Sections 10-1300 10-1302. Definitions, Jurisdictions, and Venue	1. Removal of word excessive (referring to injuries); a Child Protective program should be concerned with all injuries. 2. Additons: -- injuries resulting from serious corporal punishment. -- serious threat of harm as a form of abuse. -- the word "abandonment" to further define neglect. -- language to protect those who when legitimately practicing their religious belief, avoid certain types of medical care.
Section 10-1303 Reporting	Use of "appropriate" rather than "possible" (in phrase "to preserve family life wherever possible".)
Section 10-1304 Reports Part A	Change the words "reason to believe" to "reasonable cause to suspect". The proposed language is a lesser standard of evidence. It does not require the professional to be certain of abuse and neglect, but merely to be suspicious of it. Addition of words "known to them in their professional or official capacity" (concerning when a professional must report).
Section 10-1304 Part B	Encourages any person to report child abuse and neglect.
Section 10-1304 Part C	A new provision not found in Montana law- requiring reporting in institutions at all staff levels.

SUMMARY OF PROPOSED LEGAL CHANGES

Old Law	Proposed Changes
Section 10-1304 Part D	This part is also a new provision in Montana law. It requires all suspicious fatalities, involving adults as well as children, to be reported to a medical examiner or coroner. It also requires that the medical examiner or coroner share his findings with the hospital making the report.
Section 10-1304 Part E	Expands the present list of professionals and officials required required to report.
Section 10-1304 Part G	Proposes changes in the area of "privileged communications" for the purposes of reporting, cooperating with the child protective service, and testifying in court about known or suspected child abuse or neglect. This part abolishes the husband/wife privilege and all professional priviliges, except the attorney/client privilege.
Section 10-1304	1. Provides a penalty for failure to report. 2. Establishes a specific basis of criminal and civil liability -- "knowing and willful failure" of those required to report or act.
Section 10-1304 Part I	This part represents a totally new provision in Montana law. It authorizes persons and officials required to report to take (or arrange to be taken) photographs and x-rays without the permission of parents, which would ordinarily be required in many situations.

SUMMARY OF PROPOSED LEGAL CHANGES

Old Law	Proposed Changes
Section 10-1305 Action on Reporting	This section contains several major changes: -- The responsibility for investigation lies with not only the social worker but also with the county attorney and law enforcement agency, although the social worker carries the final responsibility for planning for the abused and neglected child. -- Language is added which allows the child abuse or neglect investigator to encompass all areas where the child is present. -- Includes a provision for investigative access to the hospital, the child, and his records if the child is hospitalized.
Section 10-1306 Immunity from Liability	Addition of the words "furnishing hospital or medical records as required". This addition strengthens the requirement that hospitals and/or private physicians produce such records and also give them immunity from any possible liability resulting from release of records.
Section 10-1308 Confidentiality	New wording imposes a penalty for breaching confidentiality.
Section 10-1309 Emergency Protective Services	Addition of an alternative to removal of child from his home -- a provision which places in law what is already a common practice in many areas: the placement of an attendant in the actual home for a brief period of time (48 hours).

SUMMARY OF PROPOSED LEGAL CHANGES

Old Law	Proposed Changes
Section 10-1315	Provides a mandate that the county welfare department be capable of responding to emergency child abuse and neglect reports 24 hours a day and seven days a week.
Section 10-1323 Guardian ad litem	Proposed wording allows a guardian who is not an attorney to be appointed when the appointing judge determines that a suitable attorney is not available. The wording also allows volunteers or privately paid guardians to serve.
Section 10-1324 Inter-agency Cooperation	1. Addition of a section which is intended to foster interaction and close collaboration among the diverse community resources that provide services to protect children and help families. 2. Addition of a subsection which gives child protection team a legal basis for operations.

PROPOSED LEGAL CHANGES

The Task Force recommended a number of changes in the current Montana law relating to child abuse and neglect, Sections 10-1300 through 10-1322 RCM, 1947. Only those sections containing proposed changes are included in the following pages.

10-1300. Declaration of policy: It is herby declared to be the policy of the State of Montana:
(1) to insure that all youth are afforded an adequate physical and emotional environment to promote normal development;
(2) to compel in proper cases the parent or guardian of a youth to perform a moral and legal duty owed to the youth;
(3) to achieve these purposes in a family environment whenever appropriate; and
(4) to preserve the unity and welfare of the family whenever appropriate.

10-1301. Definitions. (1) "Child or youth", for purposes of this law, means any person under eighteen (18) years of age.
(2) An "abused or neglected child" means a child whose normal physical or mental health or welfare is harmed or threatened with harm by the acts or omissions of his parent or other person responsible for his welfare.
(3) "Harm" to a child' health or welfare can occur when the parent or other person responsible for his welfare:
    (a) Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or
    (b) Commits, or allows to be committed, against the child a sexual assault, or exploits, or allows to be exploited, the child for sexual purposes; or
    (c) Fails to supply the child with adequate food, clothing, shelter, education, or health care, though financially able to do so or offered financial or other reasonable means to do so;
    (d) Abandons the child, as defind by law; or
    (e) Fails to provide the child with adequate care, supervision, or guardianship by specific acts or omissions of a similarly serious nature requiring the intervention of the child protective service or a court.

(4) For the purpose of this Act, "adequate health care" includes any medical or non-medical remedial health care permitted or authorized under state law. A parent or other person responsible for a child's care legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child shall not be considered neglectful for that reason alone. However, when the child's health requires it, the court may order that medical services be provided to the child.

(5) "Threatened harm" means a substantial risk of harm.

(6) "A person responsible for a child's welfare" includes the child's parent; guardian, foster parent; an employee of a public or private residential home, institution or agency; or other person legally responsible for the child's welfare in a residential setting.

(7) "Physical injury" means death, or permanent or temporary disfigurement or impairment of any bodily organ or function.

(8) "Mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within his normal range of performance and behavior, with due regard to his culture.

(9) "Dependent youth" means a youth who is abandoned, dependent upon the public for support, destitute, without parents or guardian or under the care and supervision of a suitable adult, or who has no proper guidance to provide for his necessary physical, moral, and emotional well-being. A child may be considered dependent and legal custody transferred to a licensed agency if the parent or parents voluntarily relinquish custody of the child.

(10) "Youth in need of care" means a youth who is dependent or is suffering from abuse or neglect within the meaning of this act.

10-303. Declaration of policy (reporting). It is the policy of this state to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. It is intended that the mandatory reporting of such cases by professional people and other community members to the appropriate authority will cause the protective services of the state to seek to prevent further abuses, protect and enhance the welfare of these children, and preserve family life wherever appropriate.

10-304. (a) Reports. When the professionals and officials listed in (e) of this section know or have reasonable cause to suspect that a child known to them in their professional or official capacity is an abused or neglected child they shall report the matter promptly to the Department of Social and Rehabilitation Services, its local affiliate, and the county attorney of the county where the child resides. This report shall contain the

names and addresses of the child and his or her parents or other persons responsible for his or her care; to the extent known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries or showing the willful neglect and the identity of the person or persons responsible therefore; and the facts which led the person reporting to reasonably suspect that the child has been abused or neglected.

(b) Any person may make a report under this section, if he knows or has reasonable cause to suspect that a child is abused or neglected.

(c) Whenever a person is required to report in his capacity as a member of the staff of a medical or other public or private institution, school facility, or agency, he shall immediately notify the person in charge, or his designated agent, who shall then become responsible to make the report or cause the report to be made. However, nothing in this section or Act is intended to relieve individuals of their obligation to report on their own behalf, unless a report already has been made or will be made forthwith.

(d) Any person or official required to report under this Act who has reasonable cause to suspect that a child has died as a result of child abuse or neglect shall report his suspicion to the appropriate medical examiner or law enforcement officer. Any other person who has reasonable cause to suspect that a child has died as a result of child abuse and neglect may report his suspicion to the appropriate medical examiner or law enforcement officer. The medical examiner or coroner shall investigate the report and submit his findings, in writing, to the local law enforcement agency. the appropriate county attorney, the local child protective service, and if the person making the report is a physician, the physician.

(e) Professionals and officials required by (a) to report are: any physician; resident; intern; hospital personnel engaged in the admission, examination, care or treatment of persons; nurse; osteopath; chiropractor; podiatrist; medical examiner or coroner; dentist; optometrist; or any other health or mental health professional; Christian Science practitioner; religious healer; school teacher or other school official or pupil personnel ; social worker, professional day care center or any other professional child care, foster care, residential, or institutional worker; or peace officer or other law enforcement official.

(f) Any person reporting abuse or neglect which involves acts or omissions on the part of a public or private institution, school, facility, or agency shall be responsible for ensuring the report is made to the department of social and rehabilitative services, its local affiliate and the county attorney of the county in which the facility is located.

(g) The privileged quality of communication between husband and wife and any professional person and his patient or client, except that between attorney and client shall not apply to situations involving known or suspected child abuse or neglect and shall not constitute grounds for failure to report as required or permitted by this Act; to cooperate with the child protective service in any judicial proceeding relating to child abuse or neglect.

(h) Any person, official, or institution required by this Act to report known or suspected child abuse or neglect, or required to perform any other act, who purposely and knowingly fails to do so or who purposely and knowingly prevents another person acting reasonably from doing so shall be guilty of a misdemeanor and shall be punished by a fine not to exceed five hundred dollars, or by imprisonment in the county jail not to exceed thirty (30) days, or by both such fine and imprisonment and shall be civilly liable for the damages proximately caused by such failure or prevention.

(i) Any person or official required to report under this Act may take, or cause to be taken, photographs of the areas of trauma visible on a child who is the subject of a report and, if indicated by medical consultation, cause to be performed a radiological examination of the child without consent of the child's parents or guardians. Whenever such person is required to report in his capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he shall immediately notify the person in charge, or his designated agent, who shall then take or cause to have taken color photographs of visible trauma and shall, if indicated by medical consultation, cause to be performed a radiological examination of the child. The reasonable cost of photographs or x-rays taken under this section shall be reimbursed by the appropriate local child protective service. All photographs or x-rays taken, or copies of them, shall be sent to the local child protective services at the time the written confirmation report is sent, or as soon thereafter as possible.

10-1305 Action on reporting.

Upon receipt of a report the social worker, county attorney, peace officer, or any combination of the above shall promptly conduct a thorough investigation into the home of the child involved or any other place where the child is present and into the circumstances surrounding the injury of the child and into all other matters which in the discretion of the investigator or investigators, shall be relevant and material to the investigation. The social worker shall be responsible for the family assessment and planning for the child. If the child is treated at a medical facility, the social worker, county attorney or peace officer shall, consistent with reasonable medical practice, have the right of access to the child for interviews, photographs, and securing physical evidence and have access to hospital and medical records pertaining to the child. If from the investigation it appears that the child suffered abuse or neglect, the department shall provide protective services to protect the child, to protect any other child under the same care; and to preserve the family. If the child is removed temporarily, he may not be placed in a jail. The department will advise the county attorney of its investigation. The investigating social worker, within 60 days of commencing an investigation, shall also furnish a written report to the Department of Social and Rehabilitation Services which shall maintain a record system containing child abuse and neglect cases.

10-1306 Immunity from Liability

Anyone participating in good faith in the making of a report or investigation of a child abuse and neglect report or participating in resulting judicial proceedings, or furnishing hospital or medical records as required, shall be immune from any liability, civil or criminal, that might otherwise be incurred or imposed, unless the person acted in bad faith or with malicious purpose.

10-1308 Confidentiality.

The case records of the Department of Social and Rehabilitation Services and its local affiliate, the county welfare department, the county attorney and the court court concerning actions taken under this act and all records concerning reports of child abuse and neglect shall be kept confidential except as provided in this section. Any person who permits or encourage the unauthorized dissemination of their contents is guilty of a misdemeanor. Such records may be used by interagency interdisciplinary child protection teams as authorized under section 10-1324 for the purposes of assessing the needs of the child and family, formulating a treatment plan; members of the team are required to keep

information about subject individuals confidential. Such records may be disclosed in court for in camera inspection if relevant to an issue before it; the court may permit public disclosure it is finds such disclosure to be necessary for the fair resolution of an issue before it. Nothing in this section is intended to affect the confidentiality of criminal court records or records of law enforcement agencies.

10-1309 Emergency Protective Services

(1) Any child protective social worker of the Department of Social and Rehabilitation Services, the county welfare department, a peace officer, or county attorney who has reason to believe any youth is in immediate or apparent dange of violence or serious injury may immediately remove the youth and place him in a protective facility. The department may make a request for further assistance from the law enforcement agency or take such legal action as may be appropriate. The department may also leave the child in his home and place a child protective attendant in the home for a period of forty-eight (48) hours.

(2) A petition shall be filed within forty-eight(48) hours of emergency placement of a child unless arrangements acceptable to the agency for the care of the child have been made by the parents.

(3) The Department of Social and Rehabilitation Services and the county welfare department shall make such necessary arrangements for the youth's well-being as are required prior to the court hearing.

10-1315 The Department of Social and Rehabilitation Services and the county welfare department shall have the primary responsibility to provide the protective services authorized by this act and shall have the authority pursuant to this act to take temporary, limited or permanant custody of a child when ordered to do so by the court, including the right to give consent to adoption.
The county welfare department shall be capable of responding to emergency reports of known or suspected child abuse or neglect twenty-four hours a day, seven days a week.

10-1323 Guardian ad litem
In every judicial procedure the court shall appoint for any child alleged to be abused or neglected a guardian ad litem who, whenever possible, shall be an attorney. When necessary the guardian ad litem may serve at public expense.

10-1324 Inter-agency Cooperation

(1) To effectuate the purposes of this Act, the county welfare department to the fullest extent feasible, shall cooperate with and shall seek the cooperation and involvement of all appropriate public and private agencies; including health education, social services and law enforcement agencies; juvenile courts; and agencies, organizations, or programs providing or concerned with human services related to the prevention, identification, or treatment of child abuse or neglect. Such cooperation and involvement may include joint consultation and services, joint planning, joint case management, joint public education and information services, utilization of each other's facilities, joint staff development and other training, and the creation of multidisciplinary case diagnostic teams, case handling teams, case management teams, and policy planning teams as provided in (2).

(2) The county attorney or the county welfare department may convene one or more, temporary or permanent, interdisciplinary "child protective teams" to assist in any diagnostic, assessment, service, and coordination responsibilities. The supervisor of child protective services of the county welfare department or his designee shall serve as the team's coordinator. Members shall serve at the invitation of the coordinator and shall include representatives of appropriate health, mental health, social service, and law enforcement agencies.

RECOMMENDATIONS

I. PREVENTION

1. That the Department of Social and Rehabilitation Services, in cooperation with the Department of Health and Environmental Sciences, establish demonstration projects aimed at early detection and education of high risk parents.

2. That the Department of Health and Environmental Sciences incorporate into its prenatal and well-child clinics:

   a) A method of detecting faulty parent-infant interaction.
   b) A plan to serve those found to be high risk parents.
   c) Coordination with other agencies involved in the treatment of child abuse and neglect.

II. REPORTING

1. That Montana law be amended to define all aspects of abuse and neglect more clearly.

2. That the Board of Public Education in conjunction with the Office of Public Instruction set forth a policy promoting reporting of cases of child abuse and neglect within the school systems. We further recommend that policy include provisions for continuing education of school personnel and for promoting community involvement of the schools in the handling of child abuse and neglect. The following specific procedures should be implemented:

   a) The districts should designate one person in each school to be responsible as a resource person for child abuse and neglect. When possible, the school nurse would be designated.
   b) The Board of Public Education and the Office of Public Instruction should develop training for the resource person.
   c) School districts should establish a uniform protocol for reporting, involving the teachers, principal, and nurse.
   d) The resource person should encourage reporting and be responsible for in-service training of personnel at the district level.
   e) The resource person should be compensated for his time.

3. That the Board of Regents establish a curriculum in child abuse and neglect for prospective teachers. This might best be accomplished by including it in the required child development curriculum.

4. That Social & Rehabilitation Services design an adequate and workable data system to establish the incidence of child abuse and neglect, together with necessary epidemological information. Data gathering must be streamlined, and functional for the purpose of program planning and evaluation.

5. That it be the policy of Social and Rehabilitation Services to provide feedback to referral services.

6. That all hospitals and clinics develop guidelines for reporting child abuse and neglect by their staff members.

III. A COMPREHENSIVE PROTECTIVE SERVICES SYSTEM

1. That all Montana communities strive to develop and support a comprehensive service system. That state agencies, especially the Department of Social and Rehabilitation Services provide full support to local communities in their efforts. Support may include:

   a) Training and technical assistance, especially in program evaluation.
   b) Conferences and workshops.
   c) Funding to develop new programs.
   d) A statewide newsletter.

2. That the following kinds of parenting education be offered:

   a) Family life education, through school districts for parents of school age children.
   b) Parenting skills training for the general public, especially for the identified abusive and/or neglectful parent, to be offered by mental health centers, Community Coordinated Child Care (4-C's), and other appropriate agencies.

3. That colleges, universities, and other public schools promote community education classes in areas of child development and family life. This may be implemented in two ways:

a) Accredited classes in parenting skills, such as Parent Effectiveness Training (PET), and child development.
b) Non-credit community classes.

4. That the efforts of the Department of Institutions be supported in developing quality residential treatment facilities.

5. That Social and Rehabilitation Services take action with respect to the foster care program to:

a) Provide training to all foster parents.
b) Provide for different levels of foster care, depending on training, experience, and demonstrated skills. Payment would vary with the level of care.
c) Develop therapeutic foster homes to meet the needs of disturbed children.
d) Develop appropriate supports for foster parents, including respite care for foster families.

IV. SOCIAL SERVICES IN THE COUNTY WELFARE DEPARTMENTS

1. That the Department of Social and Rehabilitation Services initiate the following:

a) Adopt a formalized 24-hour emergency intake process in all localities. The major cities are encouraged to establish specialized emergency intake units.
b) Monetary or time compensation must be provided to staff for time spent "on call".
c) Social and Rehabilitation Services should secure the necessary number of positions to ensure adequate service.
d) A case weighting system should be implemented.
e) Selection of prospective employees should be based on a proper balance between personal and professional qualifications and tests scores.
f) A degree in social work or a related field should be a requirement for employment.
g) Position vacancies should be evaluated and critical positions must be filled immediately.
h) All Social Service workers must have access to basic orientation to Social and Rehabilitation Services on the first day of work.
i) Social Services workers must be required to attend two program-related workshops each year.

j) All Supervisors must be required to attend training including orientation and on-going education in the Social Services field.
k) Paperwork must be assigned to clerical rather than professional staff.
l) There must be sufficient clerical staff.
m) Social and Rehabilitation Services must evaluate each county by need and population in order to make necessary changes and transfers in employee positions, including clerical and home attendant positions, including projected as well as actual needs.
n) Social and Rehabilitation Services must develop an evaluation system to determine which services are most helpful and to determine unmet needs.
o) Social and Rehabilitation Services must study the problem of turnover among protective services workers and implement recommendations aimed at the prevention of turnover.

2. That the services of the Attorney General's Office resolve the problems of legal representation for Social Services:

a) The legal system must provide training in child abuse and neglect to county attorneys.
b) Specialization by counsel in child abuse and neglect cases is encouraged. This may be accomplished through specialization at 1) the county level, 2) the district attorney level, or 3) the Department of Social and Rehabilitation Services for the purpose of providing legal consultation to counties.

V. THE CHILD PROTECTION TEAM

1. That legislation be enacted which would allow county attorneys or Social Services workers to develop local child protection teams for case management purposes.

2. That local community teams be established for the purpose of : 1) providing public education and 2) planning to meet local needs This responsibility should be assigned to the Child and Youth Development Bureau or other appropriate unit of Social and Rehabilitation Services.

3. That legislation be proposed to establish budget and administrative capabilities within the Division of Community Services of the Department of Social and Rehabilitation Services for support of the child protection teams to include:

   a) Public information services, such as pamphlets and a list of possible speakers.
   b) Statistical reports.
   c) Training and technical assistance.
   d) Funding for special projects.

VI. INDIAN RESERVATION AREAS

1. That Social and Rehabilitation Services develop a clear statement as to the services the agency is obligated to provide under the Title XX plan.

2. That it be the policy of the State of Montana to assist Indian tribes in the development of family programs, including those related to child abuse and neglect. Further, we recommend that state and state-administered federal funds be used to assist in the development of child abuse and neglect codes.

3. That the Governor establish planning meetings for the purpose of reviewing existing problems on each reservation. It is recommended that this be accomplished before the Title XX Service plan for the next biennium (February 15, 1979). It would be hoped that these meetings would result in cooperative arrangements for better services. Those who should attend include:

   a) Representatives of the tribes, including the tribal council and a tribal judge.
   b) Representatives of each contiguous county welfare department.
   c) Representatives of the Bureau of Indian Affairs.

4. That the Social and Rehabilitation Services continue to document the need for child protective services on the reservations and that this documentation be available to the public.

VII. ELIGIBILITY FOR FEDERAL GRANTS UNDER P.L. 93-247.

That state legislation be enacted to qualify Montana for federal grants under P.L. 93-247.

SECTION III: WHAT CAN BE DONE?

Selected Statistics

Child Protection Services
(Abuse and Neglect Programs)
of
Montana Social and Rehabilitation
Services (SRS)
FY 1978

Protective Services

Children contacted for investigation or services	4,146
Families contacted for investigation or services	3,000
Court cases for temporary or permanent custody of children	381

Staffing

Social Workers	127
Social Service Aides	5
Home Attendants	80

Costs

Staffing costs for Child Protection	$ 877,688
All Child Welfare Programs (Protective Services, foster care, adoption, health, outreach)	$ 1,800,000

The Billings Child Abuse and Neglect Community-Based Team
Billings, Montana

by Monica Holmes, Ph.D., and Douglas Holmes, Ph.D.

Team Coordinator: Doris Olsen, MSW: St. Vincent's Hospital
Protective Services: Joseph Cahill

START-UP

In 1967, the Montana legislature passed legislation requiring that all abuse and neglect cases be reported both to the local department of welfare and to the county attorney's office. In 1970, the county attorney for Yellowstone County became involved in a case of child abuse which was known to the chief of social services at St. Vincent's Hospital (later to become the team coordinator) and to a pediatrician (later to become a team member). The family was known to several agencies but the county attorney experienced considerable difficulty in obtaining necessary information from the other agencies involved in this particular case. Frustrated by this lack of coordination among agencies and wanting to gain some specific knowledge about child abuse, the county attorney attended a training session in Denver at the suggestion of the hospital chief of social services. Following this session, the county attorney, the chief of social services, and the pediatrician joined together to form the nucleus of what was later to become the child abuse team. At this time, it was recognized that no single agency in the community had the resources and expertise necessary to deal effectively with all aspects of child abuse, and a team approach was planned as a solution to this problem. The county attorney took the lead in seeking to broaden the team. The team was established with considerable effort; concern about jurisdiction, about roles of various members and their agencies, about possible criticism over the handling of cases, all represented constraints to the formation of the team. Despite these obstacles, persistence of concerned professionals, most particularly of the county attorney and the future team coordinator, led to the formation of the team in February 1972. By the time of initiation, jurisdictional issues had been sufficiently resolved to permit participation of all relevant agencies, and St. Vincent's Hospital had agreed to provide space, including permission to maintain a central registry of cases detected in Yellowstone County. Since that time, the State Social and Rehabilitation Services (SRS), the agency to which the local county welfare department reports, as well as the Yellowstone County Welfare Department, have played a major role in providing support to the team and its approach.

While there is no clear legal statute which either permits or prohibits the functioning of the team, the legal basis for the operation of the team stems from the fact that the county attorney may, by Montana law, call upon any relevant agency to provide information relating to a specific case of abuse or neglect; the team is regarded, in this sense, as an "agency" designated by the county attorney to provide this information. In effect, the team is seen, legally, as a consultative body to the office of the county attorney.

As attested to by the continuity of team membership and by the regularity of participation in the weekly team meetings, the problems of start-up have been resolved, although it took approximately a year for the team to define its functions, chart a regular course of operation, establish collaborative relationships among members, and identify and clarify roles of team members. The need for a coordinator and the need for the weekly case presentation to be focused and to state specific questions were not immediately apparent, but became evident once the team was in operation.

The stages in the community team development have been carefully described in a paper prepared by Pete Surdock*, ACSW, which is

*Mr. Surdock is Assistant Chief of the Social Services Bureau, Community Service Division, Social and Rehabilitation Services, Montana.

quoted at some length. The first phase is characterized by

> . . . limited role clarification best exemplified in the conflict of who was ultimately responsible for the services to the abused and neglected family. Or to state it another way, "Can we trust each other?" The second stage of the team's development can be referred to as the building of trust or team "morale." This is seen in the team's ability to see themselves as a functioning consultative unit where opinions and observations can be stated and are accepted freely and the team identity emerges . . . The focus is on a coordinated effort with minimal concern for "territory or turf," but one of who can best do the job in this case or what part is played by whom. This does not require the SRS social worker to relinquish responsibility for the case. It does require the acceptance of a new role for SRS workers which is referred to as the "case management" role . . . . The third stage of development for the team can be referred to as the continuation not termination stage. This arrives after the team has achieved a groupness and realization of their effectiveness as a unit . . . .

The Billings team can be characterized as a well-implemented community team in terms of the collaborative relationships among members.

PROGRAM OBJECTIVES

The objectives of the team are as follows:

- To provide expert consultation services to the county attorney so that he can make informed decisions as to whether or not cases will be prosecuted and what recommendations to make to the judge
- To provide consultation services to the department of public welfare in terms of recommendations for case management and disposition
- To serve as a coordinating mechanism for all agencies with an interest in child abuse and neglect
- To serve as a visible community resource for the handling of child abuse and neglect cases

Above all, it is the opinion of all team members that such a team is necessary because no single agency has the resources to cope with the problem.

PROGRAM AUSPICE

The team includes one, and in some cases two, representatives from each of the following agencies:

- county attorney's office
- department of public welfare
- St. Vincent's Hospital
- regional community mental health center
- health department

In addition, the team includes three community professionals who attend regularly: two pediatricians and a psychiatrist. However, none of these agencies constitute an auspice.

PROGRAM COSTS AND SOURCES OF FUNDING

The team receives no funding and expends no money: all of the team members volunteer their time. However, the Junior League of Billings, Inc., and the Montana chapter of the National Association of Social Workers did provide funds for printing a public information brochure about child abuse and neglect.

FACILITIES

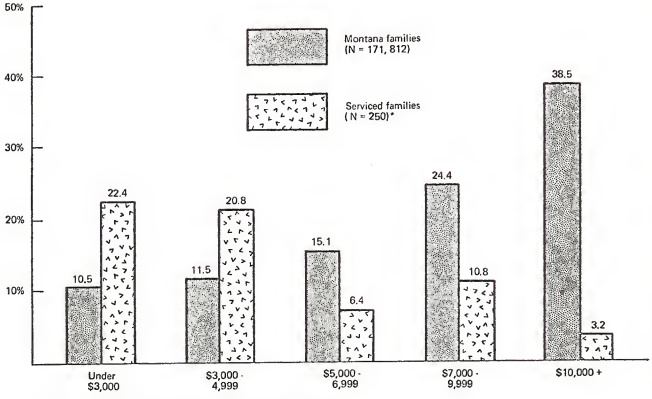
Team members use the facilities of their regular agencies and meet at St. Vincent's Hospital.

COMMUNITY AND PARTICIPANT CHARACTERISTICS

The population of Billings is 67,000. While SRS maintains extensive data based on cases in the entire State of Montana, a specific breakdown of the 42 validated cases in Yellowstone County is not available. Therefore, the data presented here are based on State rather than Yellowstone County characteristics. All data are based on the first 6 months of 1974.

SRS received validated reports on a total of 87 abusive and 163 neglectful families (123 abused and 283 neglected children). Approximately 41.7 percent of these cases are defined as recidivistic in the sense that the agency had previous records of abuse or neglect. While some were ongoing cases, the majority had already been closed prior to the new report. Approximately 11 percent of all client children were in placement in 1974.

As can be seen from figure 26, abusing and neglectful families are underrepresented in the



* The incomes of 36.4 percent of serviced families are unknown.

Figure 26. Income

higher-income groups. While 38.5 percent of the general population has incomes of $10,000 or more, only 3.2 percent of client families have such incomes. Similarly, while 24.4 percent of Montana families have incomes of $7,000-$10,000, this is true of only 10.8 percent of client families. Similarly, while 43.2 percent of the client families have incomes under $5,000, 22 percent of Montana families are in lower-income groups.

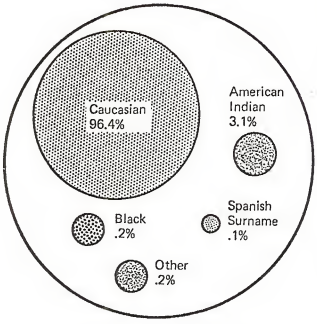
Figure 27 displays data on the ethnic status of Montana and client families. American Indians, who represent only 3.1 percent of the State's population, are overrepresented in the client group, as they comprise nearly 20 percent of client families. In general, other ethnic minority groups, i.e., Spanish-surname and black families are overrepresented in the client population. As these groups are generally overrepresented among low-income families, it is not surprising that ethnic minorities are overrepresented among client families.

Data on age distribution of children presented in figure 28 show that the largest single group of client children (33.5 percent) are 12 years of age and over, whereas children 0-3 represent the smallest client group (16.6 percent). This relatively small percentage of children 0-3 and the relatively high percentage of children 12 and over is likely to be directly related to the sources of client referral. In hospital-based programs the majority of children referred are three and under; however, only 7.4 percent of SRS referrals come from hospitals.

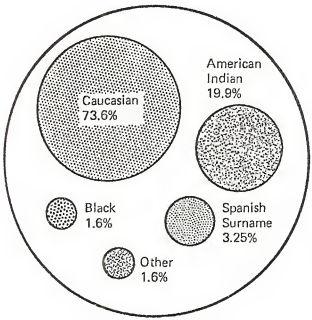
The sources of referral are presented below and, as can be seen from table 6, hospitals represent only a small proportion of all referrals.

Table 6. Sources of referral

Source	*Percent*
Neighbors	21.2
Law enforcement	17.2
Schools	15.8
Public social agencies	12.8
Relatives	12.8
Public health nurses	9.5
Hospitals	7.4
Other agencies	3.8
Total	100.5



Catchment area population



Serviced population

Figure 27. Ethnic status

THE TEAM IN OPERATION

The local department of welfare investigates each case in order to validate reports of abuse and neglect. The department's findings are reported to the county attorney who must make decisions as to whether or not to bring the case into civil or criminal court and what action recommendations to make. In civil court the choices include: request for investigative authority, temporary or permanent custody of the child, and participation in certain health and social service programs by the parents.

The team meeting is designed to provide consultative services to the county attorney regarding his recommendations and to the department of welfare regarding disposition and management. Most cases are brought to the attention of the team either by the county attorney or by the department of welfare. In some cases, the reporting source for a particular case, e.g., the hospital, may request the staffing of a case.

Team members are present at all meetings; sometimes other relevant individuals are present, e.g., police, teachers, or family physician. These individuals are part of the extended team.

The actual staffing conference starts with a brief presentation of the case and a statement as to the questions to be addressed by the team. Typically, these include questions about what recommendations to make to the county attorney, development of a case management plan insofar as the coordination of services is concerned, and a decision as to whether there is any additional information which needs to be collected. Any one case may be staffed one or more times; to date, no case has been staffed more than four times.

The team coordinator has developed and maintains a local registry of child abuse/neglect cases. By arrangement with the county attorney's office, the team coordinator receives a copy of each reporting form filed with the county attorney's office. The coordinator maintains a file of these forms which provide family identifying information, the nature of the offense, and the referral agency. Upon request from a qualified source, e.g., physician, health and welfare agency, etc., the coordinator will indicate that the family/child is listed in the registry and provide the identity of the referral agency, which can then be contacted for further information.

Approximately 75-80 percent of the cases reported to the department of welfare are staffed by the team.

The team serves as a consultative and coordinating mechanism; it does not serve a case management or treatment function. Case

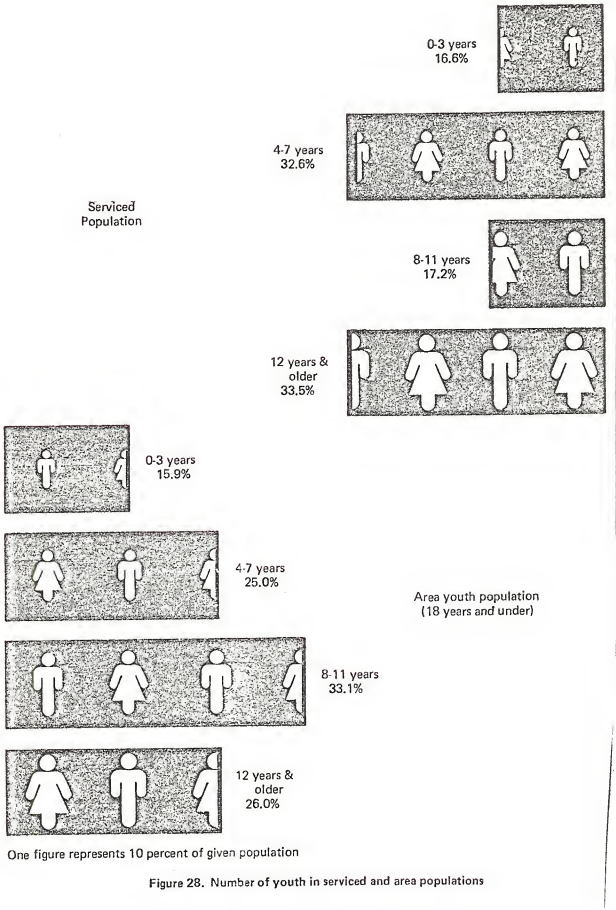


Figure 28. Number of youth in serviced and area populations

management or ongoing responsibility for service coordination and treatment are the responsibility of the department of welfare. Some clients are referred to the community mental health center for treatment.

TREATMENT

The great majority of families receive counseling services from protective services staff within the department of welfare. The protective services unit has one intake-crisis intervention worker, four workers, and one supervisor. None of these individuals has an MSW and they differ in the number of years of experience and the kinds of experience they have had. Moreover, the annual turnover rate is often more than 100 percent, as several workers may fill a single position in a single year.

The thrust of department of welfare services is to coordinate whatever other services can be obtained through other agencies and to provide short-term counseling which will help the family make some changes and get back to their pre-crisis level of functioning. If it appears that the child(ren) in a family are in immediate danger, they are removed and placed in foster care. Approximately 11 percent of all children reported are in foster care for an average period of 2 to 3 years. Children in foster care placements must be reviewed by a department of welfare supervisor every 6 months. The overall goal of treatment is the preservation of family unity.

It is estimated that approximately 50 percent of the cases are carried from 6 months to 1 year but some families are followed for less time and some have been known for as many as 4 years. Virtually all sessions are conducted in the home. Criteria for improvement include willingness to accept the department of welfare worker, improved home management capability, improvement in the children's appearance, and in the case of older children, the ability of family members to at least tolerate one another.

Contact with the majority of those families which are not in crisis ranges from once every month to once every 2 months. Staff would like to see families more often but crises interfere with more frequent contacts. Children in foster care are supposed to be seen once a month, but often are seen only once every 2 months. Once the immediate crisis is resolved and the child is determined to be not in danger, the case is closed with no further followup.

Department of welfare staff identified constraints to service delivery which include the following: inadequate services at the county level, lack of money for consultative and support services except in those cases where such services are ordered by the courts, large caseloads, staff inexperience and turnover, the difficulties inherent in establishing a relationship with multiproblem and sometimes hostile families. The caseload of each worker is between 40 and 50 families.

Treatment in most cases involves coordination of services and one-to-one contact between the mother and the worker. In the case of older children, some are seen in treatment and, in a few cases, older children are seen with their mothers or husband-wife couples are seen together. One of the staff does some work with children at the Receiving Home one afternoon a week. These are children who are awaiting foster care placement or possible return home following department of welfare investigation.

At present there are no groups and no younger children in treatment within the agency.

The following case example illustrates the conjoint counseling that some workers do in the case of older adolescents. The emphasis is very much on reality and what specific changes need to be made in order to achieve some modus vivendi for all concerned.

Brenda

Brenda is a 14-year-old girl who was continually running away from home and was very hostile to adults. She was placed in the Receiving Home and then refused to go home to her mother. The worker got the girl involved in a hobby-crafts group at the "Y" and began to see the girl with her mother once a week. These contacts continued for 7 months. The mother and daughter, who had refused to have anything to do with one another, began to speak to each other. The mother was able to see that she was extremely critical of Brenda, that she continually put her down, and was overly strict. At the same time, the girl began to make her needs known to her mother in a more reasonable and acceptable manner.

The following case illustrates the crisis nature of many of the cases:

Bella

Bella reported to the department of welfare that her 9-month-old baby had been kidnapped by his father. The baby was under treatment for a severe ear infection. The parents had been separated but had decided to try getting back together again. Finally, the child was located in a hospital in Portland with 105° fever and meningitis. The department of welfare sent Bella to Portland so that she could be with her baby; when Bella and the baby returned, the department found an apartment for them. The father was referred for treatment at the community mental health center but did not go. Ultimately, Bella was helped to join her parents in Missouri.

****

The Comprehensive Community Mental Health Center receives the greatest proportion of its support from the National Institute of Mental Health. The center is staffed by 1 psychiatrist/administrator, 4.5 social workers, 9 psychologists (of whom 5 are at the Ph.D. level), and 3 psychiatric nurses. No specific differentiation is made between cases of child abuse and neglect and other cases coming to the mental health center. Abuse/neglect is seen as only one manifestation of underlying emotional problems. Although the center might be characterized as providing primarily behavior-oriented therapy, diagnostic emphasis is placed upon underlying disorder rather than on any categorization by behavioral manifestations such as abuse and neglect.

A staff member of the center is represented on the child abuse/neglect team. However, mental health center staff frequently do not submit reports of suspected abuse/neglect to either the department of welfare or the county attorney's office as required by law, feeling that such report would seriously jeopardize the therapeutic relationship. Such reports are made only if it is felt that there is imminent danger of physical injury to the target child or if the therapeutic contact is, in effect, terminated by the client without successful resolution of the problem. It is estimated that of the approximate 25 to 30 cases known to the center per year which involve child abuse and neglect, only an approximate 12-15 are actually reported to either the department of welfare or the county attorney. Following are the mental health services provided by the center:

Initial Screening/Evaluation

At the time of intake, a general, casework-type screening is provided for all clients. Additional screening, including psychiatric evaluation, psychological evaluation, and medical diagnosis, is provided as indicated.

Psychotherapy/Counseling

The center regularly provides individual psychotherapy, couple therapy, a children's therapeutic nursery group, and mothers' groups.

Therapeutic emphasis is upon reality-oriented therapy and upon behavior modification, specifically. Case assignment, and thus the therapeutic modality, is a function of the individual conducting intake who is most likely to then become the treating person. Cases are not discussed prior to assignment to a particular therapist, and treatment modality for a particular case is determined by the therapist. Treatment is short term, with a majority of cases being terminated within 3 months and almost all within 6 months. It is felt that cases involving child abuse take longer than other cases, i.e., at the 6-month end of the continuum. There are no long-term treatment services available at the agency.

In addition to the treatment modalities noted above which are provided by a variety of different individuals representing several different disciplines, the center also provides a day care program which is primarily a behavior therapy program for hyperactive children. This program is directed by a psychologist specializing in early child development and is provided for two groups of children, 4 days a week each: 3- and 4-year-olds meet in the morning, while 4- to 6-year-olds meet in the afternoon. There are eight children in each of the two groups.

There are also two therapy groups for children which meet once a week: one for children 8-10 years old and one for children 13-15 years old. As in the other groups, emphasis in these groups is upon behavior therapy.

An adult day treatment center is also operated by the mental health center for two groups of patients: one for the chronically ill, and one for the acutely ill. Emphasis among the chronically ill is maintenance, i.e., postponing or obviating the need for hospitalization; among the acute

patients, the therapeutic regime usually extends for between 3-6 months and again involves emphasis upon socialization and behavior modification.

The center is just beginning to develop a formal, written treatment plan for each client. Particularly through a new research project, an effort is being made to develop a specific plan for each client in terms of a series of manifest treatment goals. Achievement of each of these goals is recorded and, if indicated, discussed with the patient. At times, working with the patients, the entire plan may be revised, extended, etc.

Center staff has received little, if any, training dealing specifically with child abuse and neglect. This is both reflective of, and contributing toward, the practice of the center *not* treating abuse/neglect cases differently from other cases coming to the center's attention. The center has no outreach capability and patients who are unmotivated or who skip appointments are not called or actively pursued.

THE SERVICE DELIVERY SYSTEM

All of the individuals interviewed who belong to the team, the coordinator, the two pediatricians, the psychiatrist, department of welfare staff, the mental health center representative, the county attorney, the public health nurse, feel that the team has made a great contribution in terms of agency education, consultation, coordination, and support to the department of welfare staff who take responsibility for case management. As everyone pointed out, exposure to different points of view, availability of psychiatric opinion as to the need for further evaluation and the issues to be considered, availability of legal advice, and general exchange of information are all extremely helpful. Several team members would like to see the team sponsor a lay therapist, a parent aide, or a parents anonymous program. Several agencies are clearly interested in having the team develop a treatment capability.

The team has served to focus interest and awareness of child abuse and neglect in a number of agencies. The police department, for instance, has two officers assigned to child abuse and neglect, both of whom have been to the Denver program for training. The police department feels that not only are they more attuned to abuse and neglect, but that they are also aware of the need for coordination with other agencies and feel that their relationships with other agencies have improved considerably.

Some individual team members have had impact on the agencies which they represent. For instance, the team coordinator, in her capacity as director of social services at St. Vincent's Hospital, has conducted training sessions for emergency room staff and on identification for nurses in maternity. Using a checklist developed by the team, maternity staff are encouraged to identify high-risk women who they think will experience difficulties in child care. Such cases are then followed by a public health nurse throughout the child's infancy to ensure adequate care of the baby.

COMMUNITY EDUCATION

Various team members have given talks to local civic, church, and PTA groups. The informational brochure, entitled *Help*, is reported to have been given wide distribution throughout the community.

SUMMARY OF KEY FEATURES

The Billings program illustrates the possibility of overcoming jurisdictional problems in the development of a team approach. A team in which all members act as consultants to those who are required to make decisions or to deliver services in a city in which agencies are relatively small and lack the resources of comparable agencies in larger metropolitan areas is an effective way of overcoming the lack of resources. While this type of team does not address the need of many families for a long-term supportive relationship and does not increase the level of services available, it does serve as a first step in mobilizing community agencies to deal with the problems of abuse and neglect.

Montana Child Abuse
and
Neglect Programs

Child Protection and other Child Welfare Services are offered in each of the state's 56 counties.

Child Protection Teams and/or Community Advisory Committees have been established in Cascade, Big Horn, Dawson, Fergus, Lake, Missoula, Silver Bow, Yellowstone, and Custer Counties, as well as on all Indian Reservations.

Information on Montana projects listed by the National Center on Child Abuse and Neglect (HEW Pub. PB-277-824, March 1978) has been reproduced on the following pages.

CP-01838
Beaverhead County Dept. of Welfare, Dillon, Mont.
P. O. Box 225
Dillon, MT 59725
Child Welfare Services
W. Contway, and J. Rehich

Services: The purpose of the program is to provide supervision, counseling, and day care for abused and neglected children, as well as foster homes and adoption services. Social work counseling, family counseling, employment, housing, and welfare assistance, family planning assistance, and medical care are offered directly to families. Individual therapy, residential care and health counseling are available by referral to other programs. Social worker visits with clients provide follow-up. Day care, medical care, individual therapy, specialized therapy, and foster care are offered directly to children by the program. Play therapy and individual therapy for children are available by referral.

Clientele: County residents are served.

Staffing: A social worker comprises the program staff.

Organization: The program is administered by a public agency.

Coordination: Private physicians, hospitals, schools, law enforcement agencies, concerned individuals, and abuse victims refer cases to the programs. Case reports are sent to social services authorities.

Funding: During the last fiscal year, the program income was composed of about 10 percent county funds, 70 percent state-controlled federal funds, and 20 percent state funds.

CP-01839
Big Horn County Child Protection Committee, Hardin, Mont.
P. O. Box 426
Hardin, MT 59034
Big Horn County Child Protection Committee (CPC)
J. Brown, and P. Palm.
Sep. 73.

Services: The purpose of the program is to receive referrals, provide collective advice regarding treatment, support families, and provide information to the public. All social, special, welfare, and health services, and child care services required by referral to the appropriate member agency. Follow-up is provided by professionals from the various agencies comprising the committee through direct contact and telephone calls at least once a month. A parenting group for single mothers and a prenatal class are offered as part of preventive services. Expansion of preventative programs and the organization of Big Brother and Big Sister groups are planned.

Clientele: Children, parents, and families, primarily from low-income, rural areas, are served. Clients from the Cheyenne, Crow, and Anglo-Saxon communities are served.

Staffing: There are no full-time or paid committee members. However, professionals paid by their individual agencies include child welfare personnel, doctors, lawyers, nurses, pediatricians, psychiatric social workers, psychologists, and social workers. Members of the Crow community are used in working with Indian families.

Organization: The program is a cooperative county effort. Agencies involved include the Big Horn County Dept. of Welfare, Bureau of Indian Affairs (Dept. of Interior), Mental Health Clinic, Indian Public Health Hospital, Vocational Rehabilitation, Big Horn County Schools, Big Horn County Dept. of Health, and Legal Services of Hardin.

Coordination: Medical authorities, government social service agencies, schools, law enforcement agencies, parents and neighbors refer cases to the program. Case reports are sent by name to social service authorities and the state central registry maintained by the Montana Social and Rehabilitation Service.

CP-01840
Bureau of Indian Affairs (Dept. of Interior)
Billing, Mont. Dept of Social Services.
316 N. 26th St.
Billings, MT 59101
Child Welfare Services
J. N. Burkhart
1948

Services: A part of the program is focused on child abuse and neglect. Services in the areas of identification, treatment, and follow-up are provided. Social work counseling and welfare assistance are offered directly to families by the program. Individual therapy, homemaking services, health counseling, and employment and housing assistance are available by referral to other programs. Foster care is offered directly to children by the program. Medical care, individual therapy, specialized therapy, and residential care are available by referral to other programs. Child protection services will be increasingly assumed by state agencies and tribal units in the future.

Clientele: Approximately 50 percent families, 25 percent parents, 20 percent children in groups, and 5 percent individual children, mostly from rural areas, are served.

Staffing: Child welfare personnel staff the program.

Organization: The program is administered by a public, federal agency. A special study by the National Association of Indian Women of America in Midwest, Oklahoma, is evaluating the program.

Coordination: Hospitals, government social service agencies, schools, law enforcement agencies, courts, concerned individuals, and prospective clients refer cases to the program. Case reports are sent to the legal officials, the state central registry, the National Clearinghouse for Child Abuse and Neglect in Denver, and the central office of the Bureau of Indian Affairs. Information relevant to neglect or abuse and social plans are shared with the State Department of Social and Rehabilitation Services. Evidence of neglect or abuse and information relating to disposition is shared with the tribal courts.

Funding: The program is supported with direct federal funds.

CP-01841
Cascade County Dept. of Public Welfare, Great Falls, Mont.
Social Service Div.
316 1st Ave. N.
Great Falls, MT 59401
Protective Services.
M. Mistowski, and E. Sawyer.
Jul 37.

Services: A part of the program scope is focused on child abuse and neglect. Social work counseling, family counseling, individual therapy, homemaking services, housing and welfare assistance, and family planning assistance are offered directly by the program. Some of these, along with Parents Anonymous, health counseling, employment assistance, and medical care, are also available by referral to other services. Day care and foster care are offered directly to children by the program; medical care, individual therapy, and specialized therapy for children are available by referral. Direct contact provides follow-up. A crisis hot-line is available.

Clientele: Clients are generally from mixed-income urban areas.

Staffing: Child welfare personnel, and social workers are on the program staff. Volunteers are used.

Organization: The program is administered by a public, county agency under the supervision of the State Department of Social and Rehabilitation Services. The program is evaluated by the Community Services Division of Social and Rehabilitation Services.

Coordination: Medical authorities, schools law enforcement agencies, courts, concerned individuals, and prospective clients refer cases to the program. Case reports are sent by name to the state central registry maintained by Social and Rehabilitation Services. Inforamtion required for diagnosis and treatment is shared with the Mental Health Center; medical information is shared with the city and county health departments, and pertinent case information is shared with the courts. Case reports are also sent to the National Clearinghouse for the Prevention of Child Abuse and Neglect in Denver. In the future, the program may work with a Community Child Abuse Team and increase its coordination with other agencies such as hospitals and schoools.

Funding: In the last fiscal year, the program's income was comprise of state-controlled federal funds, state funds, and county funds.

CP-01842
Choteau County Dept. of Public Welfare, Fort Benton, Mont.
P. O. Box 456
Fort Benton, MT 59442
Choteau County Welfare Services
O. Erickson.

Services: The purpose of the program is to identify, treat, and prevent child abuse and neglect and to provide appropriate protective services. Social work counseling, financial assistance, medical care, child management classes, and residential care are the chief direct services offered to parents; various other counseling services, individual therapy, and transportation are also available. Famil foster care is the principal direct service afforded to children. Individual and specialized therapy and emergency foster care are also provided. Case follow-ups vary according to the individual circumstances. A hot line is maintained.

Clientele: Children and parents in the county are served.

Staffing: One full-time social worker staffs the programs.

Organization: The administering organization function under the supervision of the State of Montana Social and Rehabilitative Services.

Coordination: The program particiaptes in interagency referrals between counties. Government social service agencies and schools constitute the major source of referrals. A significant number of cases also come through nighbors and self-referrals.

Funding: Three-quarters of the program income was derived from state-administered federal funds in the last year; the remainder came from county funds.

CP-01843
Dawson County Dept. of Public Welfare, Glendive, Mont.
P. O. Box 281
Glendive, MT 59330
Child Welfare Services
G. H. Shanley.

Services: The program focuses on services to abused and neglected children, including family reconstruction, public awareness, and removal of the child from the home when necessary. Social work counseling, family counseling, individual and group therapy, homemaking services, health counseling, employment, housing, and welfare assistance, family planning assistance, medical care, and residential care are offered directly to parents and families. Parents Anonymous, individual therapy, health counseling, family counseling, and employment are available by referral. Some of these and legal services are purchased. Day care, medical care, individual therapy, specialized therapy, foster care, and residential care are offered directly to children by the program. Therapy is available by referral. Individual therapy for parents and children, and health counseling and family planning are available by purchase. Direct client contact and collateral contacts, as needed, provide follow-up.

Clientele: Those served are individual children, parents, and families from mixed-income, rural and inner-city areas.

Staffing: Child welfare personnel, and homemaker specialists serve on the program staff. Fifteen volunteers are used as Big Brothers and Big Sisters, and as a child abuse team. Team volunteers include a doctor, a psychologist, a school counselor, a special education teacher, and a social worker.

Organization: The program is administered by a public, county agency under the supervision of the State Department of Social and Rehabilitation Services. Supervision and evaluation are carried out by state personnel utilizing on-site visits case record reviews, and the Montana Computer reporting System.

Coordination: Medical authorities, schools, law enforcement agencies, and concerned individuals refer cases to the program. Case reports are sent by name to the social services authorities and the state central registry; case reports are sent to the police, juvenile services, and health departments only when they are directly involved in the case. Evaluations and counseling services are purchased from Region 5 Mental Health Clinic. Family health and planning services and drug and alcohol counseling are purchased from Dawson County Family Planning Clinic.

Funding: The program is funded primarily by state-administered federal funds.

CP-01844
Fergus County Dept. of Public Welfare, Lewistown, Mont.
Rm. 308 Bank Electric Bldg.
Lewistown, MT 59457
Child Protection Team.
B. Johnson, and T. O'Hare.
Dec. 74

Services: The program is focused primarily on child abuse and neglect. Services in the areas of identification, prevention, treatment, and follow-up are provided. Social work counseling, couples and family counseling, individual therapy, homemaking services, employment, housing and welfare assistance, and medical care are also available by referral or by purchase. Day care, medical care, individual therapy, and foster care are offered directly to children by the program; medical care is purchased, and individual and specialized therapy are accessible by referral or purchase. Follow-up consists of telephone calls and personal and collateral contacts, as needed.

Clientele: Children to age 18, parents, and families are served. Clients are primarily from mixed-income, rural areas. Services are also provided to lay audiences, professional groups, and schools.

Staffing: Public health workers, social workers, legal personnel, and home attendants volunteer their services.

Organization: The program is administered by a public, county agency under the supervision of State Social and Rehabilitation Services. Evaluation, based on individual case management and results, is performed at the county level.

Coordination: Private physicians, schools, law enforcement agencies, courts, the Public Health Department, concerned individuals, and abuse victims refer cases to the program. Case reports are sent by name to the legal officials, juvenile services, social services authorities, health departments, the state central registry, and the National Clearinghouse for Child Abuse and Neglect in Denver. Complete written reports are sent to the county attorney's office, and base line data are sent to the state.

Funding: The program's income is derived from state-controlled federal funds and county funds.

CP-01845
Hope Ranch Project, Poplar, Mont.
Box 1136
Poplar, MT 59255
Hope Ranch Project
S. C. Roberts, and K. E. Barsness
Jan. 72.

Services: The program scope is focused primarily on child abuse and neglect. Social work counseling, lay therapy, group therapy, couples and family counseling, individual therapy, and employment, housing and welfare assistance are offered directly by the program. Some of these, along with health counseling, are also available by referral. Medical care and residential care are purchased from other programs. Children are directly furnished play and individual therapy, foster care, and residential care; medical care, and specialized therapy are available by referral. Weekly and semi-monthly home visits, office visits as needed, and continuous consultations with other involved agencies provide follow-up. Addition of a day care and child training unit is planned.

Clientele: Approximately 50 percent individual children, 25 percent parents, and 25 percent families are served. Clients are mostly from low-income, rural areas. In the last fiscal year, 35 children, 18 parents, and 22 families were identified, treated, and followed up.

Staffing: Child welfare personnel, family counselors, house-parents, program evaluators, and research specialists serve the program.

Organization: The project is a private, nonprofit organization sponsored by the Fort Peck Tribal Council; outside consultation and evaluation as well as an internal on-going evaluation are utilized.

Coordination: Government social service agencies, schools, law enforcement agencies, courts, relatives, acquaintances, and abuse victims refer cases to the program. Case reports are sent by name to the tribal court (on progress), social service authorities, and schools and churches (regarding behavior). Client evaluation is shared with the Detoxification Center; social history and treatment is shared with Mental Health and Public Health; and care and placement information is shared with the Bureau of Indian Affairs, Social Services.

Funding: The program's income was comprised of approximately 27 percent federal funds and 73 percent private funds, from a foundation and personal donations, in the last year.

CP-01846
Lake County Dept. of Public Welfare, Poison, Mont.
804 Main St.
Poison, MT 59860
Social and Rehabilitation Services
F. J. Kens, and B. Mueller.

Services: The purpose of the program is to prevent child abuse and neglect by fostering family living and parenting, and providing services to the community. Social work counseling, family counseling, homemaking services, housing and welfare assistance, medical care, and residential care are offered directly to families. Individual therapy, health counseling, employment assistance, and family planning assistance are available by referral to other programs. Children are furnished with day care, medical care, and foster care. Visits with clients ever 3 months and re-evaluation of placements every 6 months provide follow-up.

Clientele: Children, parents, and families from low-income, rural areas are served.

Staffing: Social workers and home attendents are on the program staff.

Organization: The program is conducted by a county agency under supervision of the State Department of Social and Rehabilitation Services. Program evaluation is carried out on the state level.

Coordination: A child abuse team is being established in conjunction with the Flathead Reservation service personnel. Government social service agencies, schools, doctors, law enforcement agencies, courts, concerned individuals, and abuse victims refer cases to the program. Case reports are sent to social services authorities and the state central registry. Information is freely shared with the Bureau of Indian Affairs, Branch of Social Services, the Flathead Alcoholism and Drug Treatment Program, and law enforcement officials.

Funding: During the last fiscal year, the program income was based on 25 percent state funds, 50 percent state-controlled federal funds, and 25 percent county funds.

CP-01847
Lewis and Clark County Dept. of Public Welfare, Helena, Mont.
616 Helena Ave.
Helena, MT 59601
Lewis and Clark County Public Welfare Services.
N. Waterman.
1935

Services: Part of the program is focused on child abuse and neglect, with identification, prevention, treatment, and follow-up services provided. Social work counseling, homemaking services, and housing and welfare assistance are offered directly by the program. Group therapy, family counseling, individual therapy, health counseling, child management classes, and employment housing and welfare assistance are available by referral to other services. Family planning assistance, medical care, and residential care are purchased from other programs. Day care, therapeutic day care, and foster care are offered directly to children by the program. Play therapy, individual therapy, and specialized therapy are available by referral, and medical care and residential care are purchased from other services. Personal contact with the client from weekly to quarterly intervals provides follow-up.

Clientele: Approximately 70 percent families, 20 percent children, and 10 percent parents are served. Clients are primarily from low-income, rural and suburban areas. In the last fiscal year, 10 children, 5 parents, and 50 families were identified; 10 children received preventive services; 10 children, 10 parents, and 50 families were treated; and 20 children, 10 parents, and 60 families were followed up.

Staffing: Child welfare personnel, homemaker specialists, and social workers are on the program staff.

Organization: The program is conducted by a county agency under the supervision of the State Department of Social and Rehabilitation Services Evaluation is maintained through reports to the state office and federal surveys.

Coordination: Medical authorities, social service agencies, schools, law enforcement agencies, courts, concerned individuals, and abuse victims refer cases to the program. Case reports are sent to social services authorities and the state central registry.

Funding: Approximately 40 percent county funds, 40 percent state-controlled federal funds, and 20 percent state funds comprised the program income during the last fiscal year.

CP-01848
Madison County Dept. of Welfare, Virginia City, Mont.
P. O. Box 75
Virginia City, MT 59755
Child Welfare Services
E. Smith.

Services: The program is primarily focused on child abuse and neglect, with identification, prevention, treatment, and follow-up services provided. Social work counseling, couples and family counseling, individual therapy, welfare assistance, and family planning assistance are offered directly by the program. Employment assistance and medical care are available by referral. Day care, medical care, and foster care are offered directly to children by the program. Speech or specialized therapy and residential care for children are available by referral to other services. Monthly personal visits with clients provide follow-up.

Clientele: Approximately 90 percent families, 5 percent individual children, and 5 percent parents, mostly from rural areas, are served. In the last fiscal year, 4 families were identified, and 2 families received preventive treatment and and follow-up services.

Staffing: Social workers are on the program staff.

Organization: The administering agency is under the supervision of the State Department of Social and Rehabilitation Services. The state office provides program supervision and evaluation.

Coordination: Medical authorities, schools, law enforcement agencies, courts, and concerned individuals refer cases to the program. Case reports are sent to the police or court officials and the state central registry. Other information is shared with the county attorney, doctors, and government officials. The director is shared with other welfare programs.

Funding: The program's income was drawn from state funds, state-controlled federal funds, and county funds in the last fiscal year.

CP-01849
Mineral County Dept. of Public Welfare, Superior, Mont.
P. O. Box 626
Superior, MT 59872
Mineral County Public Welfare.
E. S. Brader

Services: Part of the program is focused on child abuse and neglect. The program concentrates on prevention services. Social work counseling, welfare assistance, family planning assistance, medical care, and residential care are offered directly to families. Foster care is offered directly to children by the program; medical care and individual therapy for children are purchased from other services. Monthly follow-up is provided when necessary.

Clientele: Those served are individual children and families primarily from rural areas. In the last fiscal year, 8 children and 3 parents received preventive services.

Staffing: Social workers are on the program staff.

Organization: The program is conducted by a county agency under the supervision of the State Department of Social and Rehabilitation Services. Program evaluation is carried out by the state district office.

Coordination: Private physicians, law enforcement agencies, and acquaintances refer cases to the program. Case reports are sent to social services authorities, the state central registry, and the National Clearinghouse for Child Neglect and Abuse in Denver.

Funding: Approximately 50 percent state funds and 50 percent county funds comprised the program income in the last fiscal year.

CP-01850
Missoula Child Protection Team, Mont.
301 Alder
Missoula, MT. 59801
Missoula Child Protection Team.
G. Peterson, and B. Collins.
Jan. 74.

Services: The program is primarily focused on child abuse and neglect, and provides treatment and follow-up services. Interdisciplinary consultation to agencies providing direct services is offered by the program. Indirect services for children are handled through consultation with social workers. Case review, usually every 70 days, provides follow-up. A move into direct program development is planned.

Clientele: Those served are primarily families from low-income, urban areas. In the last fiscal year, 28 families were treated and followed up.

Staffing: Team members of the program serve on a voluntary basis.

Organization: The program is a private, non-profit organization. Periodic reviews of cases are performed to determine appropriateness and effectiveness of case planning.

Coordination: Private physicians, government social service agencies, and schools refer cases to the program. Case reports are sent to the social services authorities.

CP-01851
Missoula County Dept. of Public Welfare, Missoula, Mont.
301 W. Alder
Missoula, MT 59801
Child Protection Team
B. W. Wright

Services: The program serves in an advisory capacity to social workers and other members of the community in dealing with child abuse and neglect. Team members also participate actively in cases. The program is changing from advising on selected cases to reviewing all valid abuse and neglect cases reported to the local office of Social and Rehabilitation Services.

Clientele: Lay audiences, professional groups, and paraprofessional groups from the county are the program clientele.

Staffing: The program is staffed by a 6-member multidisciplinary interagency team consisting of a physician, a registered nurse, an attorney, a psychologist, a social worker, and a police officer. The team members serve in conjunction with their agency staff and professional positions.

Coordination: Serving as an interagency committee, the team members represent the county attorney, police, community mental health agency, public health agency, state and county social services, and a private physician. Government social service agencies provide most of the case referrals with occasional referrals from private social service agencies, physicians, and dentists. Public awareness and education campaigns have been conducted for local schools and the state education assosciation.

CP-01852
Montana Advisory Council on Children and Youth, Helena.
P. O. Box 1723
Helena, MT 59601
Montana Advisory Council on Children and Youth
C. E. Welch, and G. Fenn.

Services: Part of the program is focused on child abuse and neglect. Education on child neglect and abuse is provided.

Clientele: Those receiving education on abuse and neglect are children in groups, parents in groups, familie, and students. Clients are from mixed-income, rural and suburban areas.

Staffing: Community planners are on the program staff.

Organization: The program is a Citizens Council organization under the supervision of the State Department of Social and Rehabilitation Services.

Coordination: The program staff is shared with the Montana Department of Social and Rehabilitation Services. No direct services or referrals are given.

Funding: The program's income was based on 75 percent federal funds distributed through the state and 25 percent state funds during the last fiscal year.

CP-01853
Montana Deaconess Medical Center, Great Falls, Mont.
1101 26th St. S.
Great Falls, MT 59404
Montana Deaconess Medical Center Child Abuse Team
J. Severns
Apr. 75

Services: The program is focused primarily on child abuse and neglect. Social work counseling, Parents Anonymouse, couples counseling, individual therapy, and medical care are offered to parents. Follow-up is provided through the Welfare Department.

Clientele: Those served are individual children and parents; they are primarily from mixed-income, urban areas. Services are also provided to professional and paraprofessional groups.

Staffing: Team members who spend time with children and parents include a physician, nurses, a social worker, and a chaplain. All members except the social worker are regular hospital staff.

Organization: The program is conducted by a private, non-profit organization.

Coordination: Medical professionals refer cases to the program. Information pertinent to the case of a hospitalized child is shared with the County Department of Social and Rehabilitation Services; a social worker is also shared with this agency.

CP-01854
Mountain View School, Helena, Mont.
2260 Sierra Rd. E.
Helena, MT 59601
Mountain View School.
D. P. Robel
1919

Services: Part of the program is focused on child abuse and neglect. Residential care, medical care, play therapy, individual therapy, specialized therapy, education, work programs, and psychological counseling are offered directly to children by the program.

Clientele: All the girls have been declared delinquent by a Juvenile Court; some clients have been neglected or abused in the past. Those served are from mixed-income, rural, suburban, and urban areas.

Staffing: Personnel include 10 teachers, 3 caseworkers, 21 housemothers, administrators, and support and maintenance staff.

Organization: The school is a public, state agency under the supervision of the State Department of Institutions. The school is a correctional and educational institution for delinquent girls.

Coordination: Courts refer cases to the program.

CP-01855
Musselshell County Dept. of Public Welfare, Roundup, Mont.
P. O. Box 304
Roundup, Mt. 59072
Musselshell County Child Protective Services Project.
R. L. Hanson, and B. Johnson.

Services: Part of the program scope is focused on child abuse and neglect. Social work counseling, group therapy, family counseling, individual therapy, homemaking services, health counseling, child management classes, welfare assistance, and family planning assistance are offered directly to families. Many of these, along with employment assistance and medical care, are also available by purchase or referral. Individual therapy, day care, and foster care are offered directly to children. Therapeutic day care, medical care, play therapy, and residential care for children are purchased from other programs; and many of these along with specialized therapy are also available by referral. Case consultation with the supervisor every 2 weeks and meetings of the Child Abuse and Neglect Team 6 times annually provide follow-up.

Clientele: Those served are primarily families from mixed-income, rural areas. In the last fiscal year, 6 families were identified, 4 families were treated, and 2 families were followed up.

Staffing: Social workers and home attendants are on the program staff.

Organization: The program is administered by a public county agency under the supervision of the State Department of Social and Rehabilitation Services. The County Child Abuse and Neglect Team evaluates the program.

Coordination: Schools, law enforcement agencies, courts, concerned individuals, and abuse victims refer cases to the program. Case reports are sent to the legal officials, social services, and the state central registry maintained by the state social and rehabilitation service. Background information is shared with the County Attorney and the Mental Health Satellite Office. Full information on the case is shared with the County Sheriff's Office if they refer the case.

Funding: The program's income consisted of 75 percent state-controlled federal funds and 25 percent county funds in the last fiscal year.

CP-01856
Park County Dept. of Public Welfare, Livingston, Mont.
414 E. Callender
Livngston, MT 59047
Park County Public Welfare
K. E. Banschbach

Services: The major service to parents is financial assistance. Social work counseling, homemaker services, transportation, individual therapy, babysitting, employment assistance, and 24-hour counseling are also offered. Day care and emergency foster care are offered to children. Direct contact or telephone follow-up is carried out while the case is active.

Clientele: Last year more than 40 low-income families from Park and Meagher counties were served.

Staffing: The staff consists of 2 full-time social workers and a full-time homemaker specialist.

Organization: The program is administered by the Park County Department of Public Welfare and is under the direct supervision of the MOntana Department of Social and Rehabilitation Services.

Coordination: The program participates in some child study teams. Most of the cases are referred from the schools, and many others come from law enforcement agencies and the courts. Some are referred by relatives, neighbors, and social service agencies.

Funding: Monies derive from state funds, state-administered federal funds, and county funds.

CP-01857
Public Health Service (DHEW), Billing, Mont.
Billings Area Indian Health Service.
P. O. Box 2143
Billing, MT 59103
Indian Health Services.
F. W. Dixon.

Services: The purpose of the program is to provide consultation and assistance to Indian Health staff providing direct services, and to organized Protective Services Teams. Social work counseling, family counseling, individual therapy, and medical care are offered directly to parents and families. Welfare assistance and family planning assistance are available by referral to other programs. Medical care is offered directly to children by the program, and foster care is available by referral. Follow-up is provided by semi-annual direct contact.

Staffing: Public Health Service physicians, psychiatric nurses, psychiatrists, physicians' aides, and social workers are on the program staff.

Organization: The program is administered by a federal public health agency.

Coordination: Six of the eight reservations have Child Protection Teams which consist of medical consultants, tribal representatives, public health nurses, juvenile authorities, state child welfare personnel, and Bureau of Indian Affairs representatives. Case reports are sent to Tribal Law and Order and the Bureau of Indian Affairs. Case descriptions and the diagnosis (if written consent is obtained) are shared with the Welfare Branch of the Bureau of Indian Affairs and tribal officials. Case information is also shared with Child Welfare of the county of residence. Child Protective Team members (from various involved disciplines) hold monthly meetings at each reservation to discuss cases and also development in the area of child abuse and neglect.

CP-01858
Richalnd County Dept. of Welfare, Sidney, Mont.
221 5th St. S. W.
Sidney, Mt. 59270
Richland County Welfare
S. L. Rau, and V. Knapp

Services: A part of the program scope is focused on child abuse and neglect. Social work counseling, family counseling, individual therapy, homemaking services, housing assistance, and welfare assistance are offered directly to parents and families; health counseling, child management classes, and residential care are available by referral, and individual therapy, family planning, and medical are available by purchase. Day care, individual therapy, and foster care are offered directly to children; medical care, play therapy, individual therapy, and speicalized therapy are purchase from other programs; and therapeutic day care and residential care for children are available by referral. Personal contact with clients 1 month after the close of services provides follow-up. A team approach was initiated recently.

Clientele: Approximately 50 percent families, 25 percent children, and 25 percent parents, mostly from low-income, rural areas, are served. In the last fiscal year, 20 children, 12 parents, and 9 families were identified and followed up; 3 children, 4 parents, and 3 families received preventive services; and 18 children, 8 parents, and 6 families were treated.

Staffing: Child welfare personnel and social workers are on the program staff.

Organization: The program is administered by a public, county agency under the supervision of and evaluated by the State Department of Social and Rehabilitation Services.

Coordination: Medical authorities, government social service agencies, schools, law enforcement agencies, courts, concerned individuals, and abuse victims refer cases to the program. Case reports are sent by name to the social services and the state central registry. Richland County Public Health provides nurses for the program and family planning services are purchased from Dawson County Family Planning in Glendive.

Funding: The program's income is composed of state funds, state-controlled federal funds, and county funds.

CP-01859
Rosebud County-Northern Cheyenne Child Abuse and Neglect Service Demonstration Project, Forsyth, Mont.
P. O. Box 903
Forsyth, Mt.
Child Abuse and Neglect Service Demonstration Project.
K. Keyes, and B. Bay.
Aug. 75.

Services: The purpose of the program is team identification and treatment of child abuse and neglect in rural areas and on Indian reservations, Direct services to parents include social work counseling, homemaker services, 24-hour counseling, individual therapy, transportation, babysitting, lay therapy, child management classes, couples counseling, and family counseling. Individual counseling is the principal direct service for children. Also offered are individual therapy, medical care, play therapy, emergency and family foster care, and academic tutoring. A 24-hour hot line is maintained to receive reports and provide crisis intervention. Follow-up is conducted by home visits on a monthly basis for 6 months to 1 year following termination of services.

Clientele: Fifty-five county children to age 18 years, 38 parents, and 18 families have been served. Indirect services are provided for lay audiences, professional groups, and paraprofessional groups.

Staffing: The full-time staff consists of 4 social workers and 2 homemaking aides.

Organization: This state-sponsored child welfare program is under the supervision of the State of Montana Department of Social and Rehabilitation Services.

Coordination: The staff participates on a multidisciplinary team consisting of representatives from medicine, public health nursing, psychology, law and child development. A reservation team includes, in addition to those above, 3 public health workers, a social worker, a probation officer, a tribal court judge, and 2 Burea of Indian Affairs social service specialists. Most referrals are received from neighbors, probation departments, relatives, and government social service agencies. About 40 percent of the cases are referred to state agencies. Psychiatric consultation, parent effectiveness training, and testing are purchased from other agencies.

Funding: State-administered federal funds support the program.

CP-01860
Silver Bow County Dept. of Public Welfare, Butte, Mont.
County Courthouse
Butte, Mt. 59701
Children's Protective Services Program
Q. Lynch, and R. Colvill

Services: The program is primarily focused on child abuse and neglect, with identification, prevention, treatment, and follow-up services provided. Social work counseling, couples and family counseling, individual therapy, homemaking services, welfare services, and medical care are offered directly to families. Lay therapy, group therapy, health counseling and child management classes are available by referral to other services. Family planning assistance and residential care are purchased from other programs. Day care, therapeutic day care, medical care, individual therapy, and foster care are offered directly to children by the program. Play therapy, specialized therapy, and special education are available by referral to other programs; residential care is purchased from other services. Monthly or every 3 month contacts with the client by the caseworker provide follow-up.

Clientele: Parents, children and families are served. Clients are primarily from low-income, suburban and urban areas.

Staffing: Homemaker specialists, social workers, case aides, and physicians are on the program staff. Volunteers provide emergency foster home care.

Organization: The program is conducted by a public, county agency under the supervision of the State Department of Social and Rehabilitation Services. The program is evaluated internally on an on-going basis; program guidance and consultation are provided by the state office. Other agencies in the community informally evaluate the program.

Coordination: A multidisciplinary team consisting of 2 pediatricians, a psychologist, 5 social workers, 2 attorneys, 2 law enforcement officers, and a counselor coordinates interagency services, and provides group decisions regarding custody of a child, the appropriate domicile for the child, and protective service program improvements. An interagency cooperative system has been developed, and an Inter-Allied Services referrral form is used to refer clients from one agency to another. Medical authorities, government social service agencies, schools, law enforcement agencies, probation officials, courts, concerned individuals, and abuse victims refer cases to the program. Cases are referrred primarily to state agencies. Case reports are sent to the police and court officials, juvenile services, social services, health departments, and the state central registry. Occasionally, information on some phase of child abuse and neglect is shared with various community groups.

CP-01861
Teton County Dept. of Public Welfare, Choteau, Mont.
Choteau, MT 59422
Child Welfare Services
L. Crabtree

Services: The program is focused primarily on child abuse and neglect. Social work counseling, Parents Anonymous, couples and family counseling, individual therapy, homemaking services, employment, housing, and welfare assistance, family planning assistance, and medical care are offered directly to parents and families. Some of these, along with group therapy, health counseling, and individual therapy, are also available by referral. Many of these services are also available by purchase. Day care and foster care are offered directly to children; individual therapy is also offered. Direct client contacts, as needed, provide follow-up.

Clientele: Approximately 98 percent individual children, 1 percent parents, and 1 percent families, mostly from low-income, rural areas, are served. In the last fiscal year, 16 children, and 3 parents were identified; 10 children and 3 parents were treated; and 16 children and 2 parents were followed up.

Staffing: Social workers are on the program staff.

Organization: The program is administered by a public, county agency under the supervision of the State Department of Social and Rehabilitation Services.

Coordination: Law enforcement agencies, courts, and acquaintances refer cases to the program. Case reports are sent by name to legal authorities and social service authorities. Any information on child abuse is shared with the State Social and Rehabilitation Service.

CP-01862
Toole County Dept. of Public Welfare, Shelby, Mont.
Shelby, Mt. 59474
Toole County Public Welfare
M. K. Thompson.

Services: A part of the program scope is focused on child abuse and neglect, with identification, treatment, and follow-up services provided. Social work counseling, family counseling, individual therapy, welfare assistance, family planning assistance, and medical care are offered to parents and families. Day care, individual theraphy, foster care, and residential care are offered directly to children by the program. Many of these, along with medical care for children, are also available by referral or purchase. Psychiatric evaluations, counseling, and home visits, usually on a weekly basis, provide follow-up.

Clientele: Children, parents and families from primarily rural areas are served.

Staffing: Social workers are on the program staff.

Organization: The program is administered by a public, county agency under the supervision of the State Department of Social and Rehabilitation Services (Title XX). The Great Falls Regional Office provides written and oral evaluations.

Coordination: Schools, law enforcement agencies, courts, concerned individuals, and abuse victims refer cases to the program.

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SPECIAL ISSUE

Child Abuse, Neglect and The Family Within a Cultural Context

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Introduction

by
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In his book on slavery, *The Peculiar Institution*, Kenneth Stampp asserts, in a plea for equal treatment, that "...innately Negroes are, after all, only white men with black skins, nothing more, nothing less."* While white women would probably have some reservation about that statement, members of non-white groups, male or female, could be expected to take a particularly dim view of it. Made during what now appears to have been America's "integrationist phase," the statement reflects what was, at the time, the fairly popular goal of achieving cultural sameness, that culture being the dominant one, i.e., middle-class, male, and white.

During the past decade, the framework for the discussion of the nation's cultural and ethnic values has shifted in substantial degree. The emphasis on homogeneity has been replaced by a celebration of difference and a search for group identity. The trend toward rejection of integration and assertion of a separate Black identity have obviously played powerful roles in influencing other groups to become more conscious of their own backgrounds, a development which has not been limited to non-whites. The recently increased attention being devoted to white ethnicity is an equally important reflection of the changing times.

These changes in our mores and attitudes toward difference and toward our own ethnic identifications have had an impact in a wide range of areas in which social interaction occurs, and they raise a number of basic questions, some of which have only begun to be addressed. For example, although it has become clear that there are significant cultural differences in child rearing patterns, there would seem to be few instances in which systematic attempts have been made by child protective and family services agencies to determine what the implications of these differences are for the nature of the services which they provide.

Anyone who has attended one of the many recent conferences on child abuse and neglect has been able to witness first-hand our failure to resolutely address these issues. First, there is the standard disclaimer to the effect that "...we all know that problems of abuse and neglect are spread throughout the socioeconomic spectrum." While it is usually not stated, these remarks imply that the socioeconomic distribution is at least relatively random and that families at various levels of society are, in general terms, equally affected. While there has been some sound research in this area, most of these assertions do not seem to be based upon any scholarly work but, instead, can be considered to be essentially self-protective. On the part of majority culture members, statements of universal incidence reflect a desire to avoid being considered racist or culturally biased, labels which are likely to follow the presentation of a contrary view, i.e., one who asserts a higher incidence of abuse and neglect at lower socioeconomic levels and among minorities.

In contrast, members of minority cultures in particular, but white ethnic groups as well, often react to what appears to be pervasive negativeness in the treatment of cultural difference by majority representatives and by the mass media. One need not look far for justification for this view. Let us take the specific example of Black children and families. Although a number of excellent studies are available, the one which was most widely discussed was done by Daniel Patrick Moynihan and described ghetto life as a "tangle of pathology." The complexity of Moynihan's position and his conclusions were largely ignored—by both Blacks and whites—and attention was sharply focused on the minority of disrupted Black families. The listing of similar examples related to other groups would not be difficult, e.g., the misuse of Oscar Lewis' work on Puerto Ricans.

One consequence of this situation in the area of abuse and neglect is the current cross cultural "dialogue of the deaf." Its most visible manifestations are the previously mentioned assertions of randomness of incidence of abuse and neglect, and a widespread pattern of verbalized cultural relativism which allows everyone to breathe a bit more easily. The prevailing rule here is that one cannot make judgements or set standards for groups other than one's own. And since there is general reluctance to wash our own dirty linen in public, we have a resultant unwillingness to seek out potentially unhappy truths on all sides. These evasions, however, prevent us from coming to grips with a number of basic issues which affect the lives of significant numbers of children and families.

First, the question of the socioeconomic distribution of problems of child abuse and neglect is an important one within several contexts. To cite only one, if the assertion of relatively random incidence is accurate, it means that the child protective agencies are not meeting the needs of a large number of non-poor children, since their caseloads are heavily weighted with poor children and families. Or conversely, if such agencies engage in unwarranted intrusions into family life, this pattern of intervention indicates that the poor are once again being doubly victimized. In addition, given a national social structure which finds a disproportionate segment of the nation's minority groups at the lower end of the scale, an assertion of even relatively equal incidence among all socioeconomic groups must raise real questions about the impact on family life of poverty, discrimination, and insensitive or socially destructive government policies, each of which are used to explain a variety of other social ills. There is a need to ask whether the conditions under which this country's poor are compelled to live do not result in the stresses and crises which are generally associated with patterns of abuse and neglect and, therefore, whether the incidence of such cases would not be greater among members of minority cultures, the most severely affected victims of social and economic injustice.

Second, while the prescribed response to questions related to cultural difference is to voice acceptance of diversity and different ways of rearing and disciplining children, the reality is that these attitudes are often not reflected at the point at which the

* New York: Alfred A. Knopf, 1956.

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system comes into contact with families. Rather than looking for deviance from the cultural norms of the "client" group, there would appear to be all too frequent assumptions that behavior *within* norms of another culture is itself deviant since it is different from the dominant one, i.e., that of most workers. Issues of social class compound those presented by differences in cultural background. For example, even workers of the same cultural group as the client may have very different class values.

One result of these gaps is that the worker's propensity to focus on weakness, already present because of the investigative role assigned to protective services, is accentuated, and little effort is made to build on strengths which are often available and which tend to be culturally variable. It is likely that workers might not even be aware that they are rigidly imposing their own cultural standards on others. In addition, given the potency of the term "racist," it may be very difficult to get individuals to openly discuss prejudices and negative stereotypes of other groups, despite the fact that such feelings are widespread in a stratified, multiethnic society such as ours.

Within this context, the ambivalence of members of non-dominant cultural groups to "the system" in general, and the child protective agency in particular, is more understandable. While everybody is opposed to the abuse and neglect of children, how one responds to a system which often seems incapable of any sort of differential diagnosis and whose outcomes sometimes appear to be more harmful than the poverty/neglect nexus, and the disproportionate number of minority children in foster care and institutions, provides more than minimal support for attitudes of ambivalence and resistance to what are seen as destructive intrusions.

A third and clearly related issue which requires systematic attention is that of the refusal to make any judgements about other cultures, an absolute culture relativism. In a sense, this issue is a mirror of the unthinking application of one's own cultural norms to other groups. Carried to its logical conclusion, cultural relativism requires the suspension of all value judgements regarding other groups because of the need to respect cultural differences. There is also a class variant here, manifested in a refusal to impose "middle-class" or "bourgeois" values on the poor.

These attitudes raise difficulties as serious as those involved in blanket application of one's own standards. What is the state's responsibility, for example, in protecting children when severe physical or emotional punishment or the denial of medical care is being justified on cultural or religious grounds? The ambivalence of representatives of the most affected groups becomes more troublesome in these areas, since, in many instances, we are dealing with cases in which children are at risk of serious harm. One can legitimately ask whether the emphasis on cultural integrity in situations such as these does not constitute another form of social fragmentation.

A derivative, but significant problem relates to the jobs provided by the provision of services to members of different cultural groups. The desire to develop or protect jobs for group members reinforces the related goal of having such services provided within the group, thus the prescription that "only X's can understand X's" or "Y's shouldn't try to work with Z's." Whose standards are then applicable: the group's or those established by law and policy?

A final issue is related to the ability of large bureaucratic organizations to respond to cultural differences in a sensitive manner which builds upon family stengths, which can be found in different forms among different groups. There would seem to be an especial need to assess the impact of institutionalization in cutting children off from their cultural roots. In addition, we should examine the operations of large human service organizations, which almost by definition, are geared to categorization and typing, to identify ways which permit their staffs to be more empathetic and sensitive. An area deserving particular attention in this respect is the professional education provided for those who will assume responsibility for providing services for members of cultures other than their own. Given their potential and actual impact on the lives of families, there would seem to be an overriding need for the systematic training of protective services workers in the areas of cultural and class differences.

Recent years have told us more about who we are not than who we are. We are not the society Martin Luther King anticipated in his "I Have A Dream" speech. Nor are we a "melting pot." In certain respects, problems of abuse, neglect, and services to families are at the cutting edge of the definition of the relationship between government(s) and specific cultural and ethnic groups. The increased federal attention to trends in families and in the condition of children in America is just one indication that the difficulties which society faces in these areas are increasingly serious.

This introduction has raised many questions and answered few. In addition to reflecting the writer's lack of answers, it has been intended to provide a framework for the series of articles which make up this special issue. The reader will find that many of the issues raised above are addressed in the pieces which follow. Given the scope of the questions related to culture and ethnicity, the issue is hardly comprehensive in its treatment. We have, however, attempted to present a range of viewpoints in the hope that the experiences described will be useful to others and that a sustained discussion of these questions will follow. The pages of the *P.S.R.I. Report* will be available to those wishing to comment upon or add to the articles in this issue.

THE SAMOANS

by
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The Samoan Islands lie some 2,200 miles from Hawaii in the South Pacific. Like Hawaii, most of the islands are of volcanic origin. Nine of the many islands in the group are inhabited and all share similar geography, with precipitous mountains and relatively little arable terrain.

Despite their common customs, language and history, the Samoan Islands are divided politically. The northern and largest islands (totalling over 1,140 square miles of land area) comprise the independent nation of Western Samoa, with a population of over 150,000. Western Samoa was previously a United Nations mandate, governed by New Zealand, and still maintains close ties with that country. To the southeast lie the small group of islands which make up American Samoa, with a total land area of only about 76 square miles and a population of just under 30,000.

Following several decades of struggle for control of Samoa during the latter part of the 19th century, Germany, Great Britain and the United States agreed, in 1899, to divide the islands. The U.S., which had been pushing for the formation of an independent Samoan kingdom, suddenly found itself unexpectedly responsible for an island dependency. With no "Colonial Office," the U.S. turned to the Navy to administer the islands, since it was the Navy's interest in Pago Pago harbor as a coaling station for its ships which drew America's attention to Samoa in the first place. The Navy administered American Samoa for 50 years until, in 1951. President Harry Truman, by Executive Order, placed the territory under the jurisdiction of the Department of

the Interior. American Samoa remains under the Interior Department and has been governed over the past 25 years by a long succession of presidentially appointed civil governors from America.

The Samoan people are Polynesians. They share a similar cultural heritage with other Polynesians, such as the Hawaiians and Tahitians, as reflected in diet, artifacts, language and mythology. In American Samoa the basic economy is one of a subsistence agriculture, although the American presence there has created a civil service class which rests as an artificial overlay on top of this basic Samoan life-style. Recent Interior Department annual budgets for the approximately 28,000 residents of American Samoa have been in excess of $30,000,000. American Samoans have benefited from cradle-to-grave free medical care and a modern medical facility, the L.B.J. Tropical Medical Center, with a doctor-patient ratio which is occasionally as low as 1:1400. Despite the ready availability of modern help, bush doctors, the Samoan version of witch doctors, do a thriving business not only in the outlying villages, but in the "urban" communities of Utelei and Pago Pago as well.

The dominant forces of the Samoan culture are the Aigas, or extended families, and the system of titled individuals headed by the Matai or chiefs. The Samoan extended family includes all one's relatives no matter how distant, and one Aiga may comprise the bulk of a whole village or even several villages. A good Samoan knows his lineage, his relatives, and the complex structure of the Matai titles in his Aiga. The Matai system occasionally results in a fafini, or woman with high rank, but it is a primarily hereditary and strongly masculine structure.

Within the village, Samoan children tend to have far greater mobility between fales or houses than do American children. Children are raised primarily by older siblings and are not infrequently brought up for varying periods of time by "Aunties" from a nearby village.

There are rather rigid rules of conduct for Samoan children. In Samoan culture it is age, not youth, which commands respect. In this regard a classic Samoan point of view holds that education is valuable in that an "educated" person is one who comprehends the complexities of Samoan structure and is familiar with appropriate social behavior.

Babies are often treated like dolls by their mothers—hugged to death one moment and then ignored or harshly handled the next—according to mother's whim. A primary responsibility of the older children is to care for their younger siblings, teach them correct social behavior, and allow them to interfere with the lives of the adults in the family as little as possible. Since problems created by little ones almost always result in the disciplining of their caretakers, the older siblings waste little time in establishing control over their little brothers and sisters by physical means.

In a Samoan family, "fa Samoa", or the "Samoan Way" dictates that young children do not sit in a house until the adults are seated; do not speak to adults unless given permission; and eat only after the adults, particularly the male adults, have had first choice of the food available. If there is little pua'a (pork) or pisupo (tinned beef—originally, "pea soup") to eat, the father will feel little compunction about eating it all and leaving only the vegetables for the children.

The installation and reinforcement of correct social behavior by young children is seldom accomplished by planned or thought-out sanctions. Instead, sanctions are usually carried out via the psychological mechanism of ridicule or by impulsive physical acts. Most common of the latter is the almost casual back of the hand blow to the heads of noisy, rude or recalcitrant children by one or the other parent. Since a great number of Samoan adults, both men and women, weigh from 200 to 300 pounds, such a blow may send a youngster sailing across the room.

If they feel their treatment is excessively harsh, even within the context of Samoan tradition, the Samoan child has the same recourse as his stateside counterpart—he can leave home. But here the similarity ends. The child will almost inevitably "run away" to the fale of a member of his extended family and the act will not cause great excitement or consternation for either household. The child may stay in his adoptive home for a day or two or, on occasion, he might remain until he becomes an adult, often within a literal stone's throw of his own home.

This easy acquisition of surrogate parents, which really begins in infancy when Samoan mothers often nurse another's infant, plus the significant role of older siblings as another form of parent substitute, has resulted in what I have to come to call an "externalized superego." Rather than introjecting or internalizing the teachings and dictates of parents, as children in our culture tend to do as a means of developing an inner superego or conscience, the Samoan child finds that, with the many "parental" figures running around in his world, it makes more sense to develop his own mechanism for determining right and wrong, outside of his internalized personality system. As a result, the Samoan learns to carefully analyze and conform to the demands of his society in order to avoid punishment and gain rewards. However, his conformity to societal expectations is closely related to his judgement regarding whether or not any socially nonconforming behavior he is contemplating, will be discovered. If the odds look good he may well do the act without guilt, if undetected, and with an exasperating lack of remorse, if caught.

Since the most important value in Samoan culture relates to the preservation of the status quo with regard to fa Samoa or Samoan customs and respect, children who violate this are typically subject to instant and, in our eyes, harsh, physical and/or emotional trauma.

The Samoan parent, who views our own children as extremely disrespectful toward their elders, finds it difficult to voluntarily mimic our child rearing ways. This is true even when he or she is attempting to acculturate into the American mainstream. The Samoan parent finds it difficult to understand why he is being called neglectful of his child, simply because three families may occupy a single, one-bedroom house, or an eight-year-old is kept home from school to take care of an infant brother so that mother can sleep. Similarly, the Samoan adult is not alarmed if a child has food which is inferior in quality and amount to that of his or her parents, or if he develops secondary infections after having a wound treated by a witch doctor . . . for these all reflect "fa Samoa," the traditional Samoan way.

Child Advocacy Conference Scheduled

A multidisciplinary panel will discuss child advocacy techniques at a conference entitled, "Make Your Advocacy Work for Children." The conference, which is cosponsored by the Regional Institute of Social Welfare Research, Inc. (RISWR), The Atlanta Junior League, and Georgia State University, is scheduled for October 26-28, 1977 at the Hyatt Regency Hotel in Atlanta, Georgia.

The goal of the conference is to improve the health, education, social, and other services for children and families in the Southeast by stimulating effective advocacy organization. Some of the topics to be covered in the three-day conference include needs assessment and monitoring, coalition building, legislative advocacy, and media development.

Further information can be obtained by contacting Sue Peters, conference coordinator, Division of Public Service, Georgia State University, (404) 658-3462.

Child Abuse: A Virgin Islands Priority?

by
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In 1975 several child abuse proposals which provided technical assistance and training to the Virgin Islands were awarded to mainland organizations. During that year the Virgin Islands had reported a total of 2 child abuse cases to the American Humane Association. With a population of 80,000 to 100,000, including an impoverished population substantially above the national average, child abuse could hardly be considered a priority concern for the Virgin Islands' human service network. Nevertheless the Child Abuse and Prevention Act of 1974 (PL #93-247) had reached the Virgin Islands and the V.I. government's priorities had once again been determined in Washington, D.C.

In a nation as diverse as the United States, it is not unusual for national policies not to address the needs of a particular state or community. However, states, unlike the U.S. territories, have more political "clout" and often can determine which of those policies can or should be implemented. The extension of federal laws to the U.S. territories, on the other hand, is done on a haphazard and inconsistent basis. Thus, for example, public welfare programs do not receive the 50% to 75% of federal funds enjoyed by the 50 states and the District of Columbia. In times of economic prosperity the Virgin Islands' government has provided the funds needed to implement programs to meet locally defined Virgin Islands' needs. However, the economic downturn of the '70's has seriously affected the Virgin Islands government's ability to adequately fund these programs. Consequently the search for new monies is undertaken with less opportunity to determine local priorities. Thus, the establishment of child abuse as a Virgin Islands priority.

The immediate implementation problem became the definition of child abuse within the context of Virgin Islands society. The last twenty years has seen the rapid transition from small isolated communities to large cosmopolitan 20th century ones. This transition has been a very difficult one for families. A large influx of West Indians from the rest of the Caribbean has reinforced some of the traditional values, while American culture has had a major impact upon the Virgin Islands by the large migration of continentals and the availability of American radio, television, newspapers, and magazines.

The conflict between these two value systems has had a serious impact on child rearing patterns in the Virgin Islands. On the one hand is the very strict authoritarian position on child rearing, where children are seen as property and parental rights override children's rights. The converse of that position supports the state's right to intervene on behalf of children and encompasses the more permissive U.S. mainland approach to child rearing, including the view that parents should respect children's rights.

The outlawing of corporal punishment in the Virgin Islands' school systems and in children's institutions, and the increase in juvenile delinquency, have led the community to believe that the two are related and that, if we revived corporal punishment, our juvenile delinquency problems would decrease. Although there is general agreement that the more obvious cases of physical abuse should be handled, the distinctions are less clear in other areas, particularly those related to discipline.

Given the above, the question becomes, how do you implement a child abuse program that makes sense for the Virgin Islands? Furthermore, how do you assist the continentals, who will provide the technical assistance and training, to support these child abuse programs in a cultural context?

A sensitizing process occurred because the individual representatives of the mainland organizations recognized and acknowledged that the V.I. was culturally different, and that training and technical assistance would have to be tailored to meet these needs. Furthermore, to be effective, trainers would have to recognize and understand the position of parental rights and the need to approach child abuse from a preventive perspective. An approach that stressed the negative aspects of child abuse would be counterproductive, whereas one that stressed reeducation, with an emphasis on growth and development of children and parental needs, would have a much more positive effect.

The current program of technical assistance and training has been tailored to meet these needs and a successful program that makes sense for the V.I. has been implemented. To date this program has included parenting skills training for a wide range of agency staffs providing services to families; a series of preventive, culturally sensitive television spots; and extensive specific training in various aspects of child abuse and neglect.

Parents Anonymous In Minority Communities?

by
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Parents Anonymous is a self-help group for parents who come together to mutually alleviate their child rearing difficulties. These parents may be currently experiencing destructive relationships with their children, or they may feel that no alternatives, other than aggressive, abusive responses to their children's behavior, are available to them. Parents Anonymous has been shown to be enormously successful in changing the abusive and neglectful behavior of its members. For example, an independent evaluation showed that member's physically abusive behavior decreased almost immediately after joining P.A. Verbal abuse continued to decrease over time.[1]

In many instances, Parents Anonymous chapters have evolved into family-like groups. Indeed, many P.A. parents are in need of the same nurturance and support considered necessary for the normal growth and development of young children. According to a Parents Anonymous manual, "The concept of the chapter as a family unit, with the chairperson as parent surrogate to chapter members, and the sponsor assuming the grandparent surrogate role, continues to this day. The basic philosophy of unconditional acceptance of the parents as they are, as worthwhile individuals in and of themselves, is indeed the kind of acceptance that children need for good nurturing and growth."[2]

How do Blacks, Hispanics and other minority groups relate to this "family unit?" How are they benefiting from Parents Anonymous? According to the evaluation by Behavior Associates, minority group representation in Parents Anonymous is relatively low—around ten percent of total membership. More specific data regarding minority group representation appeared in a recent Parents Anonymous newsletter:

Anglo—69%	Mexican-American—2%
Black—4%	Asian-American—1%
American Indian—3%	Other or no answer—20%[3]

Although the ethnic origins of a sizeable portion (20%) of the respondents is unknown, an examination of the gross numbers of chapters is revealing. There are more than 500 chapters in the country. Of these 500 chapters, according to the National Office of Parents Anonymous, two are identifiably Black and three are Hispanic.

In view of the data presented above, it appears logical to conclude that Parents Anonymous is largely a white, middle-class phenomenon. This has occurred in spite of efforts by the National Office to include minorities.

Black families in particular have been described as being more close knit, interdependent and willing to share babysitting, clothes, money, and other necessities, than whites.[4] Yet when questioned regarding Parents Anonymous, a Black parent replied, "What Black person that you know is going to sit with a bunch of white folks and tell all their business?"[5]

Is the problem of minority participation, then, one of minorities desiring not to participate in the family atmosphere of Parents Anonymous? Or is the atmosphere one based on the customs and concepts of the majority (white) family rather than a minority one? If the latter is the case, then the atmosphere must be made more conducive to minority group participation.

There are other reasons which have been postulated for the lack of Black and other minority group participation in Parents Anonymous. Some of them are:

"Black people are not nearly as alienated from their families, from their children, or from themselves as white people are."[6] Perhaps Blacks, and other minorities, have an operable system of extended family relationships which they use in time of stress. If this is so, they do not need the family atmosphere offered by Parents Anonymous because they will use their own resources in time of need.

PA is based on the concept of self-help, where members gain insight into their problems by discussing them with the group and receiving suggestions and ideas on how to change abusive behaviors from both the other parents in the group and the sponsor. It has been thought that Blacks may not participate because they lack verbal skills.

Still another reason put forth for nonparticipation by Blacks is that they are not a part of and have a basic mistrust of the "system."

Although one becomes open to criticism when advocating the development of parallel institutions, it is obvious that current strategies for chapter development almost exclusively preclude a high rate of minority group participation. A minority chapter—Black, Hispanic or otherwise—is one in which the sponsor(s), chairperson(s) and other members of the chapter are either members of that minority group, or are congnizant of and comfortable with the language and customs of that group. Such chapters are ideally located within minority communities and hold their meetings in institutions acceptable to and supportive of that community. In New Jersey, there has been some effort to implement groups to serve minority communities. These activities can be succinctly summarized as follows:

- Five hundred dollars was donated to start two groups in the Newark area—one in the inner city and one in Essex County. After nine months and numerous difficulties, one group is finally forming.
- A Black sponsor and Black chairperson were located in the city of Camden, which is overwhelmingly Black. Although Camden County has a sizeable Black population, it is primarily white. A decision was made to meet in a location just outside the city of Camden, so that both Blacks and whites could attend the meeting. The meetings have been attended mostly by white parents, with the Black chairperson dropping out.
- A Hispanic group meets in Perth Amboy, N.J. Members speak Spanish during the meetings. The sponsor and chairperson speak Spanish and a Spanish-speaking volunteer answers the telephone when parents call seeking information regarding Parents Anonymous.
- A group in New Brunswick has Black sponsors (a husband and wife team), but no other Blacks participate in the group.
- A well publicized, well planned group which meets in Bayonne, N.J., has a white sponsor, a Black chairperson and a well integrated group.

Whatever the reason for the low rate of involvement in Parents Anonymous by minority groups, a more systematic national effort should be made to provide these groups with the opportunity to participate. It is no longer enough to say that there are over 500 chapters in the nation. It is imperative that a special effort be made in every state to reach the minority groups whose numbers comprise the majority of the caseloads of child welfare agencies.

1. *Overview of the Parents Anonymous Self-Help for Child Abusing Parents Project Evaluation Study for 1974-76*, Tucson, Arizona: Behavior Associates, 1976
2. *Parents Anonymous Chairperson-Sponsor Manual*. Redondo Beach, California: Parents Anonymous, Inc., 1975.
3. *Parents Anonymous Frontiers*, Redondo Beach, California: Parents Anonymous, Inc. (Winter 1976).
4. Hill, Robert. *The Strengths of Black Families*. New York: Emerson Press, 1971.
5. Smith, Patricia T. "Towards a New Perspective . . . ." *Midwest Parent-Child Review*; Volume II, Number 2, (Winter 1976-7)
6. Billingsley, Andrew, "Family Functioning in the Low-Income Black Community." *Social Casework*, (December 1969).

Special Project Serves Native Alaskans

by
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Anchorage, the largest city in Alaska, has a population of over 200,000 people, approximately 12,000 of whom are Native Alaskan. In addition to their differences from the larger population the cultural diversity among the four main groups of Native Alaskans—Eskimo, Athabascan, Aleut and Tlingit—pose real problems to an urban native center. Each group has a distinct tradition, language and method of child rearing. However, in each group, the extended family is an important factor in both child rearing and preserving family solidarity.

The Cook Inlet Native Association (C.I.N.A.), a federally funded child abuse and neglect project, has found that here, as in many urban areas, the actual extended family was hundreds of miles away. And, although the ties to this family were still very strong, the available assistance in times of stress as well as the individual security associated with belonging to a group were greatly diminished.

Isolation in Anchorage is both geographic and psychological for many Native families. There are few neighborhoods with high concentrations of Native peoples, and the public transportation

system is often foreign to families newly arrived from a village. This isolation has serious consequences. Without support from helping persons within the Native community, the Native family in which neglect or abuse occurs is likely to be very resistant to help or change when confronted by the official agency, i.e., the State of Alaska.

C.I.N.A. has sought to overcome these difficulties. Family Aides, in part modeled on Dr. Henry Kempe's lay therapist concept, are members of the Native community and serve as helping persons. Families are better able to trust members of their own cultural group and, whenever possible, aides and families are matched in this way. Attention is focused on the parent's need to be accepted, cared about, and treated as an identifiable, dignified and important person in an impersonal environment. It is recognized that many of the parents have, in the past, experienced the closeness and intimacy of a defined neighborhood or rural community. A supportive treatment model is intended to provide access to the security, comfort, and nurturing that was once available in that environment.

The aides serve as a key resource to the community in creating an awareness about the problem of child abuse and neglect. They have been successful in communicating to the Native and non-Native community that there are effective ways to support families involved in abuse and neglect while keeping children in the home.

Simultaneously, the project staff encourages referrals to be made to the State Division of Social Services, the mandated agency, but those families which are appropriate for the project receive services immediately without waiting to be referred by the state agency. The project has maintained a small caseload with the intent of servicing families on a more intensive basis.

A large part of any program on child abuse and neglect is identification of families that are in need of services. In Alaska, for the fact identification and the subsequent investigation is done by the state Division of Social Services.

Traditionally, it has been very difficult to pinpoint families at high risk for abuse or neglect because of the number of variables (i.e. number of doctors, number of hospitals, etc.) found in most communities. In Anchorage a possible 90% of all Native people receive their medical services from the Alaska Native Medical Center (ANMC), which has made it possible for the Maternal and Child Health Care team and the C.I.N.A. Project staff to develop a program of early identification.

Alaska Native Medical Center often saw families that were high risk by definition and yet they were not able to offer services to them until actual problems arose. They felt strong'y that, if these families could be given some extra early attention at the pre- or post-natal stage, the number of actual abuse or neglect situations could be reduced. In the past, it was frustrating for the team to see these high risk families, and not be able to serve them. It is thought that by relieving many of the stresses on parents during the pregnancy, or immediately after delivery, children will be given a better chance to develop normally.

Because of the support of the ANMC staff and their conviction that early intervention could lessen these problems, C.I.N.A. established the position of outreach social worker. This person works 50% of her time within the hospital and clinic, interviewing high risk families, and is available to see anyone referred by the Prenatal, Infant or Well Baby Clinic. The rest of her time is spent in the community. Cases are either referred directly to the C.I.N.A. project or to other community services.

Family Services feels strongly that children in most instances should be given the best chance for survival living with and relating to their own parents. By building a supportive group around a family, while simultaneously dealing with problems of individual family members, families can gain strength and stay together.

FAMILIES WITHOUT PARENTS

by
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It is almost axiomatic that the Chinese family has been the bulwark of that ancient civilization. The family, with its rigidly prescribed rank and hierarchy, its duties and obligations, and its total permeation of every member's life from cradle to grave, made it the single most important socializing agent in Chinese life. However, within the last few decades, a family revolution has been taking place in China, drastically altering the structure of this social institution.

How has this affected Chinese families who have immigrated to the United States? Some of these families have come imbued with the traditional Chinese ways. Some have been affected by alterations of family life in China. Some have been exposed to the psuedo-Western ideas in Hong Kong. And inevitably, coming to the United States has imposed an extra burden on the already battered Chinese family.

To find out what is happening to the children of some of our newest immigrants from Asia, the Department of Asian Studies, City College of New York has been doing research in New York's Chinatown, under a grant from the U.S. Department of Health, Education and Welfare, Office of Child Development. The project has been investigating what happens to children and their families when they are plucked from a life-style so vastly different from the American culture. What is life like in Chinese American homes? What are the areas of conflict? What are the difficulties that must be overcome? Does bilingual education hinder or help their adjustment? Are the problems resolved through ethnic channels, through American institutions, or do they just fester, threatening to manifest themselves at a later time in a more explosive and acute manner?

From the preliminary observations, interviews, and fieldwork, definite conclusions cannot yet be drawn but some disturbing factors are apparent. In a single adjective, Chinese children in New York's Chinatown are *deprived*. They are deprived in the usual sense of the word, meaning lack of material comforts—often lacking the lowest level of basic necessities. Housing, in particular, is a problem, with children sometimes sleeping in layers of bunk beds, six to a six feet by nine feet room. They are deprived of space to run or stretch their legs, to let off some of the excess energy of growing children. They are prisoners of television, averaging six hours a day before their box-like wardens.

These and other deprivations do not necessarily leave harmful effects upon a child, but there is one deprivation, that is very widespread, which will have an indelible impact on future generations of Chinese American children. This deprivation, suffered by most Chinese children, is the prolonged absence of parents. In name, Chinese homes are intact. There is a mother and father, but parental presence is almost nil.

There are three major modes of this parental deprivation. The most prevalent is caused by the long hours that the father and mother work. Parents rarely see their children for more than one day a week, and then only for a brief period. The usual occupation of the father is some kind of restaurant work, where the working hours are from 11 a.m. until 12 midnight. While there is a day off, it is during the weekdays when the children are in school, so the children may see their father for a maximum of a half a day weekly.

The mothers invariably work in the garment factories, where they also put in from ten to twelve hours daily. The children must fend for themselves. Breakfast and lunch are offered for free in school. Day-care, or after-school centers at 3 p.m., are available, but in short supply. Some children go to sit with their neighbors in the factories. The streets of Chinatown are not fit for playing, and recreational facilities are almost nonexistent. So most children go home to crowded quarters and turn on the television.

The second mode of parental absence is found when the father works in another area of the United States—usually because he cannot find work closer to home—while the mother stays in New York to be near relatives. It is surprising to note the extent of this fractured familial setup. The third mode occurs when one of the parents is still in Hong Kong or Taiwan. In this instance, usually the father is here and the mother abroad. Generally, in this setup the children are male teenagers.

In all of these instances, since parental presence is almost nonexistent, it follows that parental guidance and supervision are lacking. Who is to teach the children what is right or wrong? Who is there when they need human contact and affection? Who is to inculcate the cultural heritage of their ancestors? Who is to give them emotional support and moral values? In addition to the cultural shock of immigration, Chinese American children are faced with the "loss" of their parents. This is the most damaging deprivation of all, and its effects will be felt not only in the present, but for years and generations to come.

ETHNICITY AND FAMILY LIFE

by
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The current discussion on the state of the family, while realistically dealing with the fact that the American family is in trouble, says too little about the persistence of diverse ethnic and cultural influences. One hears less about the persistence of ethnic life-styles than the "life-styles" growing out of the youth and feminist movements.

Family life has obviously changed a great deal in the lifetime of mature Americans. Even so, the influence of traditional family patterns which have developed over generations may still be dominant. It is these traditional forces, even those that seem to be in the process of declining, that need a more serious investigation.

The renewed interest in ethnic roots gives an opportunity to reassess the family within a pluralistic context. Ethnicity itself can only be understood in relationship to the family which, as the primary means of socialization, transmits a sense of peoplehood over generations.[1]

Insights into the relationship between ethnicity and family life cannot only be gained through scientific research, but in the qualitative observation of the daily lives of the people who come into our agencies. It can even be found in our own families, if we wish to take a look.

Within the last six months my wife and our two sons, David 15, and Steven 13, opened our home to two beautiful foster children, Angela 16, and Esther 12. All six of us feel that having grown into a larger family has deepened our feelings of caring and loving toward each other. The experience has taught us also that ethnic roots and family life are so intertwined that you cannot experience one without the other.

Our family has evolved out of an Italian-American working class background. My wife's father was Puerto Rican and her mother Italian. The roots of our foster children stretch back to the Dominican Republic. While their behavior has been modified by immigrating to the United States five years ago, and spending much of that time in child care institutions, the girls have maintained their ethnicity. What they laugh at, how they express anger, show affection, communicate, show embarassment, all differ in many ways from our family, which although third generation on my side and second generation on my wife's side, continues to maintain many traditional Italian-American values. This situation often leads to cultural miscues.

At dinner one evening, Angela sat silently not eating her steak. When we asked why she was not eating, she continued to remain silent, attempting to form the words, but simply saying "I cannot tell you." What was troubling her? Was she angry at us? Why couldn't she tell us? The problem was simply that she likes meat well-done. She found it difficult to tell us because to make such a request of the person who prepared a meal would be a sign of disrespect.

We realized that one of the major tasks in helping our girls grow and develop is to make certain that their own ethnic identity is maintained and nourished, while at the same time giving them opportunities to be exposed to new experiences, and different value systems.

The cultural bonds that extend over generations carry a historical continuity that is essential in developing a healthy identity, self-esteem and a sense of belonging.[2]

We have been often asked why we decided to take in adolescents. Well, I guess we have always wanted to have a larger family, and even attempted to adopt a child a few years ago through the Department of Social Services. However, the whole process of judging whether we were a "fit family" offended our sense of family.

My wife, who is the assistant director of nursing at a Neighborhood Health Center on the Upper West Side of Manhattan, met Angela when she came in for services. When it became necessary to find a foster placement for Angela, our family welcomed her into our home. Three months later, Esther, who had been in a residential setting for several years, came to live with us also.

This whole experience led us to begin thinking how many more "vulnerable" families, couples and individuals would accept children into their lives who need a home. I suspect that there are thousands, but they never have an opportunity to meet such children to allow the chemistry of attraction and nurturing to take over.

For example, both girls were involved with Catholic institutions for a number of years. Yet, we cannot remember when an appeal to take care of children was the subject of a sermon at Sunday mass, or when a church related group provided an opportunity to come in contact with these children. The parish and religious community are natural settings that have an ideological and historical concern with the caring of children.

What if professionals in protective services were to direct a greater attention to ethno-religio communities? I would suspect that such a strategy would provide children and adults with a greater opportunity to find each other and would increase the possibility of less children needing institutional care.

Human services professionals in their practice have generally focused on pathology, which is often an obstacle in recognizing

the strengths, resources, and the integrity and coping mechanisms that have evolved out of an ethnic identity, family, neighborhood and other natural informal helping systems.

In many ways, formal systems may only be truly effective if they are grounded in these informal networks. There are many effective forms of child care services that operate within ethnic groups. For example, in the Black community, there is a significant informal adoption of children involving grandparents and extended family. Should not an approach to the care of children include an understanding of how these informal systems work? Before we rush in with services that are often culturally incompatible with the life-styles of many ethnic groups, should we not assess what the natural systems are? Perhaps a more effective intervention by professionals would be to build upon these systems and provide the necessary supports to keep them viable. Where these systems are weak or nonexistent, new approaches should evolve out of the cultural life-style and value systems of the people they are directed to serve.

In a previous article,[3] I outlined some specific steps an agency can take to begin to identify the natural support systems in the ethnic group, family, or community. This would involve an extensive survey by the agency. The survey would consist of:

A. A profile of all families and children coming to the agency. This should provide information on how cultural factors affect family behavior and patterns of family interaction in relationships, and to what degree they affect assimilation, values, conflicts, use of an identification within family and community support systems, attitudes toward agency, therapy and perception of problems. This material is to be drawn as part of the intake process as well as from informal contacts in the community. Essentially, the following information should be elicited:

   How important are ethnic values to these families? How strongly do they identify with these values? Which do they select for special reinforcement or for replacement?

   Are there cultural strains between grandparents, parents, children and grandchildren?

   To what degree do they identify with their ethnicity—celebration of holidays, religious observance, reinforcement of values, friends and spouses of the same ethnic group? How close is the family? Are visits to nearby relatives frequent, etc.?

   What role does each member play in the family or group structure? What are their perceptions of each other's roles?

   What is or has been stressful in their lives—death, illness, loss of job, etc? How have they handled these events? What family members take strong or dependent roles? What roles do the extended family, friends or religious and social neighborhood institutions play?

   What have been their experiences with human service agencies? What are their perceptions and attitudes towards therapy and counseling?

B. Evaluation of the extent to which the professional and nonprofessional clinicians take into account cultural differences in the treatment process.

C. A community profile should be developed to identify those formal and informal systems of support in the community or communities served by the agency. It would include the demographic and historical development of the subcommunities; the spontaneous and natural support systems—family, neighborhood, self-help and peer groups, supports not directed by professionals—social, fraternal, religious and self-help organizations; and professionally directed agencies and organizations—schools, youth agencies, health and mental health agencies.

On the basis of these surveys, staff, both professional and volunteers, can be trained to utilize natural support systems in treatment and delivery of services. Programs should be developed that relate to specific new needs and new constituencies. Specific techniques and program development would then relate to creating new support systems—multiple family therapy, network therapy, educational and socialization groups for families, weekend and extended camping trips, training of families and leaders for indigenous action.

Clinicians are often unaware of the differences in ethnic patterns as expressed through a variety of family roles, attitudes, values, verbal and nonverbal behaviors. Therapeutic and counseling methods often reflect American core values—individualism, mastery over problems and planning for future goals.[4] Most Americans fall somewhat in the middle on the continuum between traditional ethnic values and modern assimilated values. It has been estimated that one in six Americans is either an immigrant or first generation American. Recent research also indicates that ethnic presence in contemporary American society is not only confined to newly arrived immigrants. Ellman estimates that there are 100,000,000 Americans about whom it is still relevant to speak of the ethnic factor.[5] Greeley in his research has found that ethnic patterns of behavior are carried into the third and fourth generations.[6] If the clinician is unaware of quality or the intensity of the ethnic factor, the treatment is likely to suffer.

Interestingly, my wife, who as a child was on welfare, will get all the kids together to clean the house before the social worker comes to visit us. As we sit with the social worker discussing how we are all getting along, the whole family knows that we maintain the "family honor" as a group. That is very Italian.

1 These ideas were developed in a discussion paper prepared by Joseph Giordano and Irving Levine for a consultation on the Family and American Pluralism, sponsored by the Institute on Pluralism and Group Identity and the Center for the Study of Democratic Institutions, Chicago, October, 1976.

2 See Giordano, J. *Ethnicity and Mental Health*. New York: Institute on Pluralism and Group Identity, American Jewish Committee, 1973, Teper, S. *Ethnicity, Race and Human Development: A Report on the State of Our Knowledge*. New York: Institute on Pluralism and Group Identity, American Jewish Committee, 1977.

3 Giordano, J. and Levine, M., "Mental Health and Middle America." *MH—The Magazine of the National Association for Mental Health*, 59(4), (Fall/Winter, 1976)

4 Papajohn, J. and Spiegel, J. *Transactions in Families*. San Francisco: Jossey Bass, 1975.

5 Ellman, Y., "The Ethnic Awakening in the United States and Its Influence on Jews." *Ethnicity*, 4, 1977.

6 Greely, A. *Ethnicity in the United States: A Preliminary Reconaissance*. New York: J. Wiley & Sons, 1974.

The next issue of PSRI Report will include articles on interagency coalitions, group work in protective services, and upcoming Institute conferences on The Role of the Media in Child Abuse and Neglect, and Alleviating Child Abuse and Neglect: The Role of Business and Labor.

The next special issue, in two months time, will be devoted to professional education in child abuse and neglect.

Meeting the Needs of Hispanic Families:
New Jersey Hispanic Advisory Panel Established

by
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On July 5, 1977, the New Jersey Hispanic Advisory Panel met for the third time. The basic reason for the efforts made by the Protective Services Resource Institute to encourage the formation of the panel is to attempt to improve the ways in which the needs of Hispanic children and families are being met, with special attention given to protective services for children. The members of the panel are:

Yolanda Aguilar, Director
Camden County Office for Children

Rocio Day, Psychiatric Social Worker
Union County Psychiatric Clinic, Elizabeth

Maria Fernandez, Child School Specialist
PROCEED, Inc., Elizabeth

David Matos, Jr., Program Officer
Center for Human Resources
Planning & Development, Inc., East Orange

Urbano Venero
Puerto Rican Congress of New Jersey
Trenton

Dr. Julio Arla, Child Psychiatrist
Union City

[redacted]o John de Dios
[redacted] County District Court, Newark

Dr. Marcos Liederman, Asst. Professor
Rutgers Graduate School of Social Work

Judge Robert Page
Juvenile and Domestic Relations Court
Camden

Gladis Viego, Asst. Supervisor
Middlesex County District Office
New Jersey Division of Youth
and Family Services

Ms. Day, Ms. Viego, Mr. Matos and Mr. Venero have been active since December 1976, in cooperation with PSRI, in taking the steps necessary to form the panel. The Institute's representative is Renée Kranz, whose function is coordination and communications liaison.

The panel is a direct outcome of the PSRI mandate to provide services in New Jersey, Puerto Rico and the U.S. Virgin Islands. Each locale has a significant Hispanic population. During its first year of operation, the Institute discovered that available materials for training and public awareness for Hispanics were extremely limited. In most instances, what did exist was a translation of English language literature. Consequently, there was no adaptation to the diverse cultural patterns represented by the various Spanish speaking groups.

These inadequacies are not limited to protective services for children. Recent literature explores similar inattention to the specific social needs of people of Hispanic background in the [redacted]ed States, despite the fact that these groups now total approximately twenty million people. Recognition of these conditions led the Institute to convene a planning and needs assessment meeting in 1976 with representatives of the Hispanic community from Puerto Rico, Washington, D.C. and New Jersey.

At that meeting, the following problems were considered worthy of attention:

1. The need for increased awareness of and sensitivity to Hispanic cultural values on the part of public and private social agencies which provide services for the Hispanic community.
2. The need for increased knowledge of the requirements for training service professionals in the dynamics which exist within the Hispanic parent-child relationship.
3. The need for establishment of two-way communication systems between the Hispanic community and all other segments of the larger community.

Early in 1977, those who had attended or expressed interest in the planning and needs assessment meeting were asked to nominate candidates for permanent membership on The New Jersey Hispanic Advisory Panel. PSRI sought identification of Hispanic individuals who were advocates of the interests of their community, with particular interest in working for the well-being of children and families. Excellence in professional or civic activities, and the need for suitable geographic representation within the state were also factors influencing nomination and selection. An attempt was made to find panelists who would be able to represent the expertise and point of view of the following fields:

1. Mental Health
2. Education
3. Social Services
4. Law and Law Enforcement
5. Medicine
6. Community Organizations

The present panel emerged out of this nominating and selection process.

On May 10, 1977, the first meeting of the panel was held at the College of Medicine and Dentistry of New Jersey—Rutgers Medical School. The main accomplishment of the meeting was to make tentative plans for programs that the panel thought worthy of implementation. These included:

1. Service Delivery
   Goals:
   A. Exploration of the ways in which additional Hispanic personnel might be added to the existing service delivery system.
   B. Assessment of service delivery needs in the Hispanic community.
   C. Coordination of services provided by Hispanic community agencies with services provided by DYFS and other non-Hispanic agencies.
   D. Identification of areas where technical assistance to Hispanic community agencies would be helpful.
   E. Education of existing non-Hispanic service agencies in Hispanic culture and Hispanic needs.

The discussion which led to the pinpointing of these goals emphasized that the lack of bicultural, bilingual workers in service delivery and law enforcement creates serious problems. For example, Spanish speaking Hispanic families with children who require medical attention need the explanations that a bicultural nurse might provide in order to help the parents adjust to

health standards and practices prevalent in the majority culture. The panel advocated the need for workers from Hispanic cultures to be available in DYFS and other service agencies because Hispanic clients are better able to form the necessary trust bonds with those workers with whom they share a mutual or similar culture. This may be based on the fear in Hispanic families of losing their accustomed moral values and family strength by being integrated into American culture. Creating the possibility of hiring bicultural personnel by eliminating unnecessary credential requirements whenever feasible was also discussed.

2. Prevention

   Goals:

   A. Conduct training and public awareness programs to help strengthen the Hispanic family faced with adapting to a new culture.
   B. Plan and conduct parenting training appropriate for Hispanic families
   C. Plan and conduct early intervention programs (including culturally appropriate intervention strategies) where needed in Hispanic families where children may be at risk.
   D. Help the Hispanic community to identify the existence of child abuse and neglect problems in their environment.

These goals were formulated after discussions based on a variety of ideas and beliefs. The problem of unemployment in Hispanic families as a significant stress factor was explained within the context of the culture perspective which places extreme importance on the fulfillment of head-of-household responsibilities by the male.

Professor Liederman spoke about research he has been doing which indicates that, in New Jersey, a significant percentage of single parents are members of the Hispanic community. These parents require training and service support from the community. The role of the educational system in prevention was explored and it was suggested that educational administrative policies need to become more responsive to the requirements of Hispanic youth.

3. Policy Impact

   The subcommittee on policy impact, Mr. Matos and Professor Liederman, gave a preliminary report at the panel's second meeting on June 1. The theme of the proposal was one of organized advocacy for a "bold new look in human relations . . . modification of systems so that an ability to change will be built in . . . systems and programs on understanding cultural differences and allowing them to exist."

They recommended the following policy changes to be adopted by institutions serving the Hispanic community:

A. Increased sensitivity to the need for recognition of cultural differences must be stressed.
B. Bureaucracy must learn to communicate in more human terms with the citizens for whom they provide services. They must learn to use communication which is less vague and less self-serving.
C. Institutional abuse and neglect of children must be increasingly exposed and eliminated.
D. Inter-agency coordination must be effected so that the many policies which may affect one individual or one family will be integrated.
E. Cost-effective coordination of services must be stressed.
F. The Hispanic community (indeed *any* identifiable community) should be encouraged by existing institutions to be the support system for itself.
G. Exploitation of Hispanic children in schools must be ended; Hispanic children must be given opportunities to succeed. Emotional "violence," which destroys the self-image of a child as he is exposed to the school system, must be identified and corrected.

When the panel resumes meeting in September, these recommendations will be refined and translated into action programs. One action program which was suggested by Dr. Marcos Liederman, Gladis Viego and Urbano Venero at the July 5 meeting is concerned with child-parent development centers for young, pregnant women.

These centers might be housed in existing day-care centers and public schools. Program goals would be to prepare the mother for parenthood in a non threatening, self-help environment, and then to continue this help into the early life of the child. The development of both child and parent would be encouraged simultaneously with curriculum, activities and training designed for the well-being of each.

Information is now being gathered from existing programs with similar goals. This information will be adapted for use in the formulation of a proposal suitable for Hispanic communities in New Jersey.

CULTURE AS A VARIABLE IN HUMAN SERVICES

by

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Culture represents a variable which many human service professionals prefer to ignore. Professional reluctance to consider cultural differentials often results from a lack of understanding cultural complexities. In the field of human relations, culture has no doubt assumed mystical proportions. To knowledgeable participants and observers, however, culture is not simply an array of mysterious clutter. Beliefs and value systems remain as behavioral imperatives to those individuals who are of a culture other than mainstream society.

This article will describe Ah-be-no-gee, a program designed to provide Minneapolis Native Americans with culturally appropriate family and children's services.[1] The program's rationale was based upon several community surveys representative of both Anglo professional and Native American community populations. The surveys pointed to an overwhelming absence of cultural understanding by Anglo professionals and a consequent lack of lateral integration of human services with the social and moral structure of the Native American community.[2]

Ah-be-no-gee does not attempt to dispell cultural mysticism. It does, however, explore natural family networks. Native American family process serves as a program guideline. Accordingly, the family structure and process represent the cornerstone of culture and the foundation for individual mental health. Ah-be-no-gee's principal service assumption is that the structural and cultural integrity of the Native American extended family network must be supported by delivery systems which reaffirm a

sense of family purpose. Its consequent task is to identify traditional, long-standing cultural attributes which have contributed to family cohesiveness, and to train as family advocates Native American students who are innately able to translate family cultural needs into service delivery systems.

Learning occurs through a rigorous field instruction program at the School of Social Work, University of Minnesota. Trainees participate in specialized seminars on Native American family development. They explore roles and articulate behaviors characteristic of Native American family units. This process would most probably have been impossible if every trainee were not a Native American. Their life experiences enabled the group to recapture critical dynamics of extended family life-styles.

Ah-be-no-gee has found that family structure contributes to three critical mental health attributes. First, Native American extended families differ from their European counterparts which define an extended unit as three generations within the same household. Rather, Native American extended families assume a distinct village-type network construct. This, of course, has significant impact upon behavior patterns. During early childhood socialization and for general orientation to living, individual transactions occur within a community milieu characterized by several incorporated households. Second, extended family structure facilitates transmission of cultural attributes which conserve family patterns and contribute to individual identity. Third, family serves as a major instrument of accountability. It sets standards and expectations which maintain the wholeness of the group through enforcement of values.

Moreover, extended family structure represents the interactive field in which human service professionals should conduct transactions. Professionals must, therefore, be cautious in formulating diagnostic statements and planning intervention methods. A brief case regarding client behavior patterns will serve to clarify this point.

A young probationer had strict court orders to remain under the supervision of responsible adults. His counselor became concerned because the youth appeared to ignore this order. The boy was constantly moving around and staying overnight with several different girls. Suspicions were that the boy was a pimp or a pusher. The girls appeared to know each other and enjoyed each other's company. Moreover, they were not ashamed to be seen together in public with the boy. Violation proceedings were being prepared.

I came upon the case quite by accident during lunch with an acquaintance who was curious about Native American behavior patterns. I knew the boy's family well and requested a delay in court proceedings to investigate the matter more thoroughly. It turned out that the girls were all first cousins of the youth. He had not been "staying overnight with them;" he had been staying with different units of his family. Each unit had what the family considered a responsible adult to supervise and care for the boy.

A revocation order in this case would have caused irreparable alienation between the family and human service professionals. The casework decision would have inappropriately punished the youth for normal family behavior. Moreover, its impact would affect people far beyond the presenting client. The young man had a family network consisting of over 200 people.

Single parents are also often misjudged by professionals. Single parent households obviously exist, but within the Native American network there is no such unit as a single parent family. Human service providers experience difficulty looking beyond nuclear family situations. They are consequently reluctant to see grandparents, aunts, uncles, or cousins as alternative support service caregivers. To recognize the closeness of these relational units in Native American families appears beyond professional capacity.

Grandparent roles provide a good example. Within the Native American family context, grandparents retain roles of obvious importance. To have their status undermined by professionals, who assume that anyone over fifty years of age is incapable of caring for children, has an alienation effect upon the whole Native American community. It also wreaks havoc upon the emotions of children.

Grandparents retain official and symbolic leadership in family communities. Both are active processes sanctioned by children. Official leadership is characterized by a close proximity of grandparents to family. It is witnessed through behavior of children who actively seek daily contact with grandparents. In this milieu, grandparents have an official voice in child rearing methods, and parents seldom overrule their elders. Symbolic leadership is characterized by an incorporation of unrelated elders into the family. This prevails during an absence of a natural grandparent, but it is not necessarily dependent upon such an absence. Often children and parents select, and virtually adopt, a grandparent. They seek social acceptance from another older member of the community. In this milieu, grandparents will not invoke strong child rearing sanctions. However, because their acceptance is sought, their norm-setting standards are seldom ignored.

Family network structure has persisted through the years largely as a result of strong family religious values. The naming ceremony, for example, survives among many Native American families. This ceremony develops a protective social fabric to provide for the health and welfare of children. It reconfirms family structure and designates official role models for children. Namesakes most often are aunts, uncles, or cousins. Unlike similar religious and cultural rituals among other groups, in this instance they become the same as parents in network structure. If hard times befall natural parents, namesakes have an obligation to provide for children.

Feasts also reinforce family structure. Three traditional feasts may be identified. Ritual feasts are standardized according to time or events; e.g., the seasons or a naming ceremony. Preventive feasts bring a family together whenever danger is imminent. Celebrative feasts are performed during special events. These feasts continue in practice in varying degrees among contemporary urban Native Americans. Minneapolis, for example, celebrated Mothers' Day 1977, with a major community feast. Sixteen Native American organizations cooperated in its planning. The feast honored grandmothers. Over 2,000 people attended this all-day celebration. It brought families together and served, so to speak, to reconfirm a collective sense of selfhood.

Space limitations do not allow for more than a brief review of issues in extended family culture. Developing human services that correlate with family attributes has obvious advantages. Minneapolis Native Americans have long documented their preference for Native American service providers who understand culture. Ah-be-no-gee, for example, receives over 90 per cent of its clientele through self-referrals from family networks. Through cultural affirmation, Ah-be-no-gee has developed a preventive care system based upon early utilization of services by families—grandparents, parents, and children. This preventive concept is not predicated upon technical sophistication. It is predicated upon families who have developed trust for Ah-be-no-gee staff. Through the development of culturally appropriate family services, we have been able to reaffirm a community of child care and concern.

1 Ah-be-no-gee is an innovative demonstration project funded by the National Center for Child Abuse and Neglect, Office of Child Development, HEW.

2 Lateral integration follows Lefton's concept of laterality, i.e., an interest in a client as a person with necessary responsiveness to client reactions. Organizations would use client reaction potential in determining formal procedures. See Mark Lefton, "Client Characteristics and Structural Outcomes: Toward the Specification of Linkages," in William R. Rosengren and Mark Lefton, eds., *Organizations and Clients* (Columbus, Ohio: Charles E. Merrill Publishing Company, 1970), pp. 17-36.

CHILD ABUSE SERVICES AND THE CHICANO FAMILY

by

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INTRODUCTION

The child abuser is characterized as being frightened, lonely, and isolated. To many Chicano parents, child rearing is a major responsibility, an effort—to some, even an ordeal. Becoming parents in the United States, where policies, attitudes and child rearing standards are at variance with their own, presents its own peculiar problems to Chicanos, particularly for the foreign-born recent arrival. We believe there are some solutions to the dilemmas faced by these parents. Chicano child abuse specialists have become convinced that traditional Anglo-child protective services produce sociocultural and psychic dysfunction for Chicano parents and children. There are indications that social work, which provides the bases for protective services, has at least tacitly accepted society's cultural disrespect of Chicanos. This situation has caused Chicano, and other minority professionals, to develop bilingual, bicultural child abuse treatment and training programs which are relevant both to Chicanos and to the culturally sensitive persons providing the services. We will explore these developments in this article.

At the time of the establishment of our major social institutions, non-whites in general played no role. So the institutions that have evolved to their present state did so in a manner that excluded a sensitivity to the specific needs and differences of non-whites.

In the Southwestern part of this country, there is a large Spanish speaking, non-white population, which was subjugated by the Conquistadors hundreds of years ago. These Indians were thought to be inferior to their conquerors and traditionally have been treated thus.

Today there is a national move afoot to deal with the problem of child abuse, and many publications make references to the "cultural aspects" of child abuse. Culture, as the term is often used, is a euphemism for race. It simply does not sound appropriate to speak of the racial aspects of child abuse. Upon close inspection, it is apparent that a disproportionately large number of those families being arrested or treated for child abuse are non-white. One response is to say that those people, in fact, abuse or neglect their children more. Another response is to say that neglected and abused populations develop life styles and family rearing practices that reflect their status.

For those involved in direct services it is now important to attempt to modify our present systems to make them more responsive to the needs of families that differ from the mainstream (white) populations. In a specific instance and on a day-to-day basis, what are some important factors which should be considered when working in a helping way with Spanish speaking/Spanish surnamed families?

Language

Starting with the most obvious problem, there are many barrio residents who have learned English as a second language. The lack of facility in English impedes social interaction with Anglo-American counterparts. Specifically, it reduces the worker's effectiveness and also the "client's" opportunity to learn Anglo-American ways by positive experiences, thus returning to the earlier more comfortable associations with community residents who are also Spanish speaking.

Spanish language deficiencies handicap most child abuse professionals in explaining the law, the court process, and other possible outcomes to a Spanish speaking family suspected of child abuse. Even the concept of a child protective social worker is alien to the recently arrived family from Mexico. In sum, every interaction between Anglo-American workers and the Spanish surnamed/speaking family is affected by the lack of knowledge of the family's language.

Interpreters are frequently used by child abuse professionals to overcome the language barrier. The interpreter is usually a paraprofessional as opposed to a professional interpreter. This "solution" allows the professional to do his or her job without having to interact directly and learn the culture of the Spanish surnamed clients. It is our experience that in interviews in which a parent was accused of child abuse, and an interpreter was involved in the interview, many translations reflected the interpreter's own feelings and biases with respect to the child abuse situation.

Language differences can be dealt with by:

1) employing bilingual and bicultural professionals; 2) spending a great deal more time with the non-English speaking family and gathering pertinent information from indirect sources; 3) getting operational feedback from the family; 4) never assuming that the Spanish surnamed person who speaks English also reads English (a common mistake); and 5) asking clients to educate the worker about the differences between their culture and that of the worker.

The Chicano Family Structure

The average Chicano family is poor and lives in conditions worse than those that existed during the great depression. According to Diaz-Guerreo (1975) the family (familia) is likely to be the single most important social unit in the life of the Chicano. Further, he defines the parental roles as: a) the unquestioned and absolute supremacy of the father; and b) the necessary and absolute self-sacrifice of the mother. The children are seen as a source of security for their parents in later years and not as a liability. The sons are viewed as greater resources because the daughters will marry into other families, partially severing their affiliation with their own family.

Religion is still very much a part of every day life of the Chicano family. The families tend to be larger than the national average and the birth rate is rising.

Any successful family treatment plan must include the husband/father in the initial interview, for if his place in the family structure is not respected there is little chance of developing a therapeutic relationship with that family.

The traditional extended family (familia) only asks for assis-

tance under dire circumstance and with a sense of having failed as a family. It is easy to forget how hard it is for the individual to ask for help when most clients come to the agency asking for help.

In sum, it is essential that social service agency staffs be aware that the family is usually poor, extremely needful, desperate and ashamed to be in need of help.

Personal Communications

Finally, the culture of the Chicano, Spanish speaking clients places a tremendous value on close, warm, personal relationships. One of the most frightening things about our health care delivery system is the often cool, technical, crisp, efficient, and impersonal way that clients or patients are handled. The therapist, working with the Chicano family should be aware that demonstrative behavior, friendliness, and informality are not viewed negatively by most Chicano families. The Chicano expects the services or treatment to be personalized and informal. In fact, traditional concepts of professionalism may place impenetrable barriers between the social worker and the Chicano family.

Reference

Diaz-Guerrero, R., *Psychology of the Mexican*, Austin and London: Univ. of Texas Press, 1975.

The Neglect of Black Children

by
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Children's Service, Inc
Philadelphia, Pennsylvania

A few years ago, we discredited external factors in the determination of neglect and concentrated on "pathology." In the current economic crisis, however, it has become less difficult to see the connections between economics and misery, including neglect. The determination of child neglect is further complicated by cultural differences. The following instances from the caseload of the Children's Service, Inc. illustrate the point:

❁

A young single mother living alone was charged with neglect because she took her baby with her to the local bar. The alternative was to leave the baby alone, since there was no money for a baby-sitter and no one she could trust who would keep the baby without charge. The bar was managed by a young man whose family lived above the bar and whose children were frequent visitors to and helpers at the bar. Is neglect relative?

❁

A mother of a large family had her older children removed from her custody because they did not attend school regularly. When time came for the six-year-old to enroll, the mother complied with the expectation regarding innoculations by taking the child to a "free clinic." The child had eczema, a condition which precludes injections, which was highly visible and although the clinic had a full medical history, they proceeded with the injections. As a result, the child became quite ill, and the mother was charged with neglect. The victim is the perpetrator?

❁

The grandmother of three adolescents had been named their legal guardian when their mother deserted and the father died. She struggled to provide for the children despite her own physical limitations and the responsibility of an invalid husband. When the 13-year-old grandson developed a bad toothache, she took him to a local dentist. After the dentist was assured that her "white card" (Medicaid) was valid for payment, he proceeded with a root canal job in a fully abcessed mouth. After the adolescent became extremely ill, the authorities determined that the grandmother's limitations amounted to neglect and all three grandchildren were removed and placed in a foster home. Is this neglect, or malpractice?

❁

The families in the cases described above were all Black. The services they received appear to be related to their poverty and their race. When a poverty-stricken Black child comes to the attention of a public or private agency, for whatever reason, it is imperative that he or she receive adequate health services. In a typical year 30% of Black Americans do not see a doctor, 66% do not see a dentist. Black people comprise less than 12% of America's population, but are 31% of all its poor people. Almost one out of every three Black families earns less than $5,000 a year.[1] When one becomes aware of these figures, the issue of the relationship between race and poverty is readily apparent.

Much of the lifestyle and "culture" designated as Black has been dictated by economics rather than choice. It is difficult, however, to accept the assumption that strong family ties, fidelity in marriage, education, economic security, gratification in honest work, pride in the accomplishment of children, respect for poverty, love of country, and reverence for God are the exclusive values of people who earn between $6,000 and $15,000. As a people, we Americans see orderliness as symbolic of high morals and disorder as symbolic of low morals. We strive for perfection because we feel it is more important to *be better* than to *be useful*. With our obsession with order, good appearance, and perfection, is it any wonder that we find ourselves in conflict with people whose confrontation with survival is too imminent to involve concern about the order or appearance of things?

Black families see nothing inherently wrong in leaving younger children in the care of older ones. Usually older children are trained in child care by participation in basic family functions. Family position may be more significant than sex, and role distinction is not rigidly adhered to. Boys learn to cook and diaper babies, and girls learn to putty windows and repair iron cords. All learn how to deal with bill collectors, welfare workers and other "intruders."

Black parents who are emotionally weak often turn to their children for strength so that in caring for the younger children the older child may be buttressing the parent's adequacy. Caring for the younger children voluntarily may insulate them from the frustrations of an upset parent and offer emotional stability at a level that meets the physical and psychological needs of the younger children.

Black parents who cannot handle authority may designate it to one of the children who can carry it well. Such a child may or may not be the first born. This practice of delegating authority makes the confrontation with authority a reality in the life of young children. Often, it is assumed there is no symbol of authority if there is no male adult in the home. In actuality, the task is to determine who carries the authority and how far and effective that authority is.

The practices listed above are manifestations of two basic strengths of Black families as related to child rearing. They are:

1. Black parents demand time for themselves and children come to respect the "demand for privacy" as a privilege of adulthood and a necessity for the survival of both parents and families. This "demand for privacy" prepares children for the time they will be without the parents. The Black father will die seven years before the Black mother and the Black mother will die several years before a white mother. When one also considers the high rate of incarceration for the Black male and the rate of mental breakdown among Black women, it becomes clear that Black children may be parentless more often, and at an earlier age, than children in the general population.
2. Black parents take a more humane approach to children. They do not perceive children as helpless but relate to a child's level of functional adequacy. Likewise, they do not perceive children as faultless or genuflect to their children physically or psychologically. At a young age, children are designated responsibilities which makes it possible for the family to survive. They share in the decision making by presumption, if not by open vote. For example, they may sacrifice class trips at school so the family can pay on a second-hand car to go picnicing at the beach or see relatives in the South.

Where discipline is concerned, any service or attitude about service which undermines the authority of Black parents should be weighed carefully before implementation. From an oppressed minority status in society, abusive language and behavior is often the only way a Black adult can establish authority with children and adolescents. Hardly anything in society supports the worth of a father who is long-term unemployed or a female head-of-household whose public assistance check cannot be stretched to cover both necessities of life and two digit inflation.

As Black families will vary in their values, poor families will vary because of the unusual psychological stress of a bankrupt emotional economy. Therefore, it would be wise to try to determine what certain situations mean to families. To assume that a family is without any food, even though there is a five pound can of grits in the otherwise empty refrigerator may be presumptious. In many families as long as there are grits, there is hope!

Prevention is the key to services because the cures are too far removed, except when politically advantageous. Public and private agencies must have easy access to research findings and new approaches, especially in treating neglectful parents. Public agencies cannot fulfill their mandate to Black and poverty-stricken people without full support at all voluntary and governmental levels.

1. *Must I go Hungry Again this Christmas.* New York: NAACP Special Contribution Fund, 1976

In fiscal year 1976 the Office of Child Development of the Department of Health, Education, and Welfare, through the National Center on Child Abuse and Neglect, funded more than seventy-five research and demonstration projects. Of these, 12 were designed to meet the needs of specific cultural groups. Two of these projects have been described in this newsletter. The titles and addresses of all the projects are listed below:

Makah Child Development Services Center
Ellen Ides
Makah Tribal Council
P.O. Box 115
Neah Bay, Washington 98357

Urban Indian Child Resource Center
Agnes F. Williams, M.S.W.
Indian Nurses of California, Inc
390 Euclid Ave. Oakland, California 94610

An Exploratory Investigation of Potential Societal and Intra-Familial Factors Contributing to Child Abuse and Neglect
Robert J. Bentley, Ph.D.
National Council for Black Child Development
1411 K St., N.W., Suite 500
Washington, D.C. 20005

San Antonio Child Abuse/Neglect Research Project
Dario Chapa
Mexican American Neighborhood Civic Organization
2811 Guadalupe St. San Antonio, Texas 78207

Migrant Child Abuse and Neglect Prevention Project
Oscar L. Villarreal
Texas Migrant Council
2200 Santa Ursula Laredo, Texas 78040

Cook Inlet Native Association Child Abuse and Neglect Program
Barbara Pighin
Cook Inlet Native Association
670 W. Fireweed Lane
Anchorage, Alaska 99510

Montana's Rosebud-Northern Cheyenne Child Abuse and Neglect Demonstration Project
Karen Keyes
State Department of Social and Rehabilitation Services
P.O. Box 903
Forsyth, Montana 59327

Developing a Community of Child Care and Concern for Urban Native American Children and Families
John Red Horse, Ph.D.
University of Minnesota
School of Social Work
400 Ford Hall
Minneapolis, Minnesota 55455

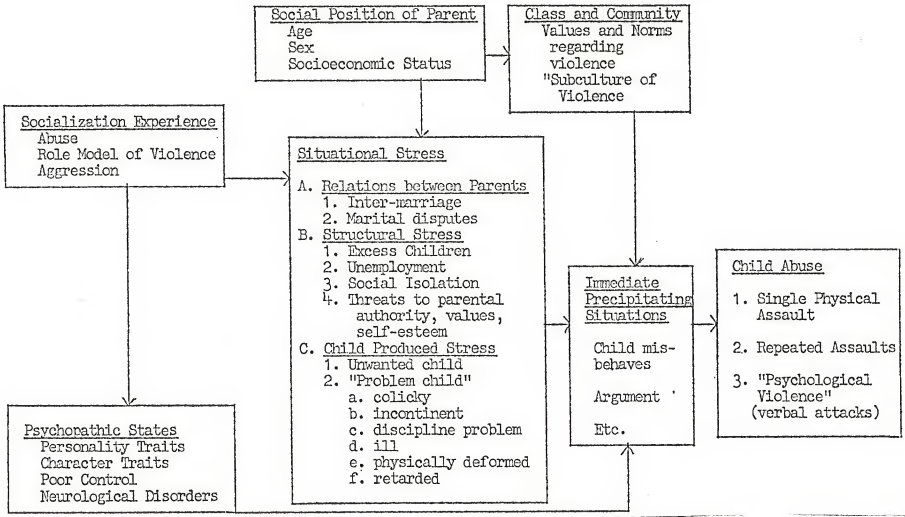
Choctaw Center on Child Abuse and Neglect
Joseph J. Renaud, Jr.
Director, Choctaw Child Advocacy Program
Mississippi Band of Choctaw Indians
Route 7, Box 21
Philadelphia, Mississippi 39350

National Urban League Child Abuse and Neglect Project (Project Thrive)
Natalie A. Dowdell, M.S.S.A.
National Urban League, Inc.
500 East 62nd Street
New York, New York 10021

Project Ku-nak-we-sha' (Caring)
Maxine W. Robbins, A.C.S.W.
Confederated Tribes and Bands of the Yakima Indian Nation
P.O. Box 632
Toppenish, Washington 98948

Appalachian Citizens for Children's Rights
Patricia M Keith, M.S.W.
Family Service Association
364 High St.
Morgantown, West Virginia 26505

CAUSES OF CHILD ABUSE



Reproduced from: Richard J. Gelles, Ph.D., "Child Abuse as Psychopathology: A Sociological Critique and Reformulation", American Journal of Orthopsychiatry, 43(4), July, 1973, p. 619.

Identification of High Risk Family Situations

The child has symptoms of:

1. injuries attributed to an accident[a];
2. poisoning or ingestion[b];
3. failure to thrive[c];
4. prematurity, especially with medical complications;
5. physical neglect, including malnutrition, dehydration, and growth retardation;
6. emotional neglect or abuse, including social and emotional retardation, and maternal deprivation;
7. neurological disorders and brain damage;
8. mental retardation;
9. sexual exploitation or abuse[d];
10. unusual and severe punishment, such as cigarette burns and linear marks;
11. repeated abuse and/or neglect[e];
12. death from unexplained circumstances[f];
13. the nonexistent complaint[g].

The parent or caretaker is:

1. acutely or chronically depressed;
2. emotionally ill;
3. physically ill;
4. mentally retarded;
5. misusing drugs or alcohol[h];
6. a young parent, wed or unwed, with little "mothering experience";
7. a product of an abusive or neglecting home;
8. a very isolated individual without an adequate support system;
9. living under stressful situations, such as unemployment, financial problems, and marital discord.

(a) Unusual and repetitive accidents, especially in infants and young children, may be the first danger signal. In approximately 10 percent of all cases of children coming into an emergency room for treatment of an injury, the parents are unable to produce a logical explanation of how the injury occurred. (Holter, J. C. and Friedman, S.B., "Child Abuse: Early Case Finding in the Emergency Department", Pediatrics, Vol. 42, No. 1, 1968, p. 136).

(b) Parental carelessness has been frequently a factor in child poisonings. Parents, who are depressed or heavily tranquilized, have been found to be more remiss in handling their medications in the home and in supervising their children. Despite an ingestion, parents usually do not change unsafe methods of handling medications and other harmful substances.

(c) A recent study has shown that an infant "who is hospitalized for failure to thrive, and in whom, after extensive investigation, no pathologic diagnosis can be made, may be at risk of serious injury or violent death within the ensuing months." (Koel, B., "Failure to Thrive and Fatal Injury as a Continuum", American Journal of Diseases of Children, Vol. 118, October, 1969, p. 565).

(d) The U.S. Public Health Service, National Communicable Disease Center, has recently cautioned that "with gonococcal infection in children, the possibility of child abuse must be considered".

(e) The severe permanent damage associated with the "battered child syndrome" usually does not occur with the initial incident. Early identification offers an opportunity for intervention with the goal of preventing subsequent trauma and irreversible injury to the children. (Friedman, S.B., "The Need for Intensive Follow-Up of Abused Children", in Helfer, R.E., and Kempe, C.H.: Helping the Battered Child and His Family, 1972, p. 79)

(f) Some instances of the Sudden Infant Death Syndrome need an psycho-social evaluation and home study. Studies have shown relationships between SIDS rates and lack of prenatal care, illegitimate births, maternal age of less than 25 years, and low birth weights. Investigating after an unexplained death is for the protection of the child's siblings.

(g) Particular attention should be paid to young mothers who come to the emergency room or the office with numerous complaints regarding their infants' health, but no disease is found. A parent may manufacture symptoms for a variety of reasons. The doctor must be alert to what the parent is "not saying" about the baby and not turn the parent off with the emphatic statement, "There is nothing wrong with your baby!" It should be assumed that something is wrong in the parent-infant relationship. Eventually, the mother may be asked,"Are you afraid of hurting your baby?" Often she will admit that this is what she has been concerned about. Here is a situation in which if the staff hears the message, intervention can

come in time to prevent injury to the child. If attention is not paid to the mother's signals for help, the result may be a child so badly damaged that he cannot be restored to his previous healthy state. (Kempe, C.H., "The Battered Child and the Hospital", Hospital Practice, Oct. 1969, p. 53.)

(h) Addicted parents have little tolerance for irritable and crying babies. Of of the implications of neonatal drug withdrawal is the fact that addicted parents abuse their infants. The death rate is believed to be high.

THE POSSIBILITY OF PHYSICAL ABUSE SHOULD BE CONSIDERED WHEN SOME OF THE FOLLOWING ARE PRESENT:

When the Parent:

1. Shows evidence of loss of control, or fear of losing control.
2. Presents contradictory history.
3. Projects cause of injury onto a sibling or third party.
4. Has delayed unduly in bringing child in for care.
5. Shows detachment.
6. Reveals inappropriate awareness of seriousness of situation (either overreaction or underreaction).
7. Continues to complain about irrelevant problems unrelated to the injury.
8. Personally is misusing drugs or alcohol.
9. Is disliked, for unknown reasons, by the physician.
10. Presents a history that canot or does not explain the injury.
11. Gives specific "eye witness" history of abuse.
12. Gives a history of repeated injury.
13. Has no one to "bail" her (him) out when "up tight" with the child.
14. Is reluctant to give information.
15. Refuses consent for further diagnostic studies.
16. Hospital "shops" .
17. Cannot be located.
18. Is psychotic or psychopathic.
19. Has been reared in a "motherless" atmosphere.
20. Has unrealistic expectations of the child.

When the Child:

1. Has an unexplained injury.
2. Shows evidence of dehydration and/or malnutrition without obvious cause.
3. Has been given inappropriate food, drink and/or drugs.
4. Shows evidence of overall poor care.
5. Is unusually fearful.
6. Shows evidence of repeated injury.
7. "Takes over" and begins to care for parents' needs.
8. Is seen as "different" or "bad" by the parents.
9. Is indeed different in physical or emotional makeup.
10. Is dressed inappropriately for degree or type of injury.
11. Shows evidence of sexual abuse.
12. Shows evidence of repeated skin injuries.
13. Shows evidence of repeated fractures.
14. Shows evidence of "characteristic" x-ray changes to long bones.
15. Has injuries that are not mentioned in history.

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*Helfer, R.E. and Kempe, C.H., "The Child's Need for Early Recognition, Immediate Care and Protection", in Helping the Battered Child and His Family. Lippincott. Philadelphia. 1972. p.73

WAR CHART


Conception
Wanted & Unwanted
Pregnancy
Child
Unrealistic Expectations
Role Reversal
Compliance
Childhood Missed
Trust Not Learned
Isolation
Inability To Help Others
I'm No Good
Inability To Help Others
Selection of Friends
Selection of Mate
Mate No Help
Separation & Divorce
WAR

HUMANISTIC TREATMENT OF FATHER-DAUGHTER INCEST*

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INTRODUCTION

The incest taboo is found in all known cultures, ancient, primitive or civilized. It is generally agreed among social scientists that the essential purpose of the taboo is to optimize the survival and expansion of social systems (1). Incest rules remain the most sternly enforced regulations for sexual relations and marriage throughout the world. But as social systems differ, so do incest rules. To this day, laws defining and penalizing incestuous relationships vary markedly among nations and among states in the United States. In England, the law regards incest only as a misdemeanor. The penalties for incest in the United States range from a $500 fine and/or 12 months in Virginia, to a prison term of 1-50 years in California (2). In most but not all states, first-cousin marriage is illegal. Rhode Island permits first-cousin marriage only between Jews (3). For the purpose of this article, incest is defined as sexual activity between a parental figure and child or between siblings of a nuclear family. The focus will be on father-daughter incest as treated by the Child Sexual Abuse Treatment Program (CSATP).

Dread of incest is buried deeply in the unconscious of man and evokes emotions that are volatile and unpredictable (repugnance, uneasy fascination, fear, guilt and anger). This confused state finds expression in obscene comments or nervous disinterest when the subject is brought up in conversation, or quickly erupts into hostile behavior when an incestuous situation is discovered. Professional helpers are not free of the incest dread. Many react either evasively when a case is referred or irresponsibly by failing to comply with child abuse reporting statutes. Nor

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* In Child Abuse and Neglect - The Family and the Community, Helfer, R. E. and Kempe, C. H., Editors, Ballinger Publishing Company, Cambridge, Massachusetts (1976).

can criminal justice personnel claim immunity from the panic induced by incest since their effect on sexually abusive families usually adds up to either rejection of the child's plea for help, if the evidence is not court-proof, or severe punishment of the entire family if the offender confesses. Finally, social scientists must also be afflicted with the dread of incest. How else can we account for the paucity of studies on incest which, for few exceptions, are superficial in conception and scope?

Typically, the repertory of law enforcement officials in the handling of father-daughter sexual abuse is ineffective and unpredictable. In one instance, the police officer and/or the district attorney may simply drop the case because of insufficient evidence even though there is strong suspicion that the victim's accusations are based on fact. The emphasis on a provable law violation has the effect of the community's turning its back on the child and family and leaving them in a worse condition than before. The child feels abandoned and must now face her hostile father, mother and siblings alone. Often the father, though he may not repeat the crime, uses subtle retributive measures such as restrictions, extra chores, ostracization, etc. In another instance, the criminal justice system seeking sound, indisputable evidence descends on the child and family with terrifying force. From the clinically detailed police reports, it appears that the only interest in the child is for the testimony she can give for conviction of her father. The entire family is entangled in the web of retribution. The child is picked up and brought to a children's shelter, often without the mother's knowledge. The father is jailed and the mother must place her family on welfare. In sum, the family is dismembered, rendered destitute and must painfully find its own way to unification.

Neglect of the sexually exploited child by the American community is vividly dramatized by Vincent de Francis in a report presenting the results of a three-year study in New York. He stresses that: "The victim of incest is especially vulnerable. The child is overwhelmed by fear, guilt and shame. Substantial damage to the point of psychosis may ensue." As a rallying cry for action he adds: "I firmly believe that no community, rural or urban, can say such cases are unknown to it. Suffice it to say the problem of sexual abuse is a real one! It is a problem of immense proportions! It is pervasive!" (4).

INCIDENCE AND EFFECTS OF INCEST

De Francis' alarm does not seem justified in view of the small number of detected incest offenders recorded annually by Western nations. Over the period 1907-38, Weinberg determined that detected incest occurred in about one to two cases per million people in the United States; in Europe, the number of detected incest offenders ranged from one to nine cases per million (5). These rates seem to hold up to 1960 (6). All writers agree, however, that the low figures are 'the tip of the iceberg'; that the laws discourage detection and that data-gathering methods render

comparative studies extremely difficult if not impossible.

In the United States some improvement in detection and treatment of child abuse is developing as a result of rising public agitation. One tangible outcome of this pressure was the passage in 1974, of the Child Abuse Prevention and Treatment Act which led to the establishment of a National Center on Child Abuse and Neglect in the Children's Bureau, Office of Child Development.

Douglas J. Besharov, Director of the Center, clearly spells out the position of the new Federal resource on the overall problem of child abuse and neglect:

> The reality of child abuse is so awful that a harsh, condemnatory response is understandable. But such reactions must be tempered if any progress is to be made. If we permit feelings of rage towards abusers of children to blind us to the needs of the parents as well as of the children, these suffering and unfortunate families will be repelled and not helped. Only with the application of objective and enlightened policies can treatment, research, prevention and education be successfully performed (7).

Other hopeful signs are the expansion and bolstering of child abuse reporting laws by many states, the increased attention being given by the media, and the growing number of hotlines, several offering a 24-hour service exclusively to calls on child abuse.

Though major interest has been on child battering and neglect, some attention is slowly turning to sexual molestation. In a recent issue of Children Today, devoted entirely to child abuse, Sgroi submitted an article in which she deduces that the above-mentioned developments had much to do with a sharp increase in reported incidents of child sexual abuse in Connecticut. The number of such incidents came to 76 in fiscal year 1973, but rose markedly to 172 cases in fiscal year 1974, apparently as a result of strengthened child abuse reporting statutes, the opening of a hotline and a persistent public education effort (8).

The CSATP serves Santa Clara County which has a population of 1,159,500 (December 1973). In 1971, its first year of operation, the program was referred 36 cases. The annual referral rate increased slowly over the subsequent two years, but during fiscal year 1974, the rate accelerated sharply to 180 cases. The burgeoning rate can only be attributed to added coverage by the media and to growing confidence in the CSATP approach. Even this rate of 180 cases of recorded incest in a population of 1.1 million inhabitants does not provide an accurate estimate of the actual prevalence of incest in Santa Clara County. Although this is a large jump indeed from the two incest cases per million, estimated for this country by the writers cited above, the true incidence of incest has yet to be established. All available figures are at best educated guesses.

More telling than guesses on the number of actual cases is the societal price paid for the neglect of incest which is beginning to surface through recent studies revealing the effects of incestuous experiences on child victims. James surveyed 200 prostitutes in Seattle, Washington, and found that 22% of the women were incestuously assaulted as children (9). For several years, Baisden has researched Rosaphrenia: "An individual who cannot accept her own sexuality regardless of how she practices sex." He discovered that an inordinately high percentage of women so afflicted were raped as children. Here, rape is defined as sexual exploitation of girls by much older males (10). Concentrating on a group of 160 women, who he tested for Rosaprenia, he found that 90% had been raped during childhood, 22.5% by fathers or stepfathers (11). The Odyssey Institute, in New York, interviewed 118 female drug abusers to ascertain their sexual history. It was determined that 44% of the women had experienced incest as children. The 52 incest victims confided that of the 93 different incestuous offenders, a total of 60 were in the parental generation, and of this group 21% were fathers or stepfathers (12). It is notable that in each of these three studies of troubled women a background of father-daughter incest emerged in over 20% of the subjects.

FATHER-DAUGHTER INCEST

Father-daughter incest is potentially the most damaging to the child and family. Certainly it is the form most frequently prosecuted by the courts.

A typical father-daughter incestuous relationship imposes severe stresses on the structure of the family. The father, mother and daughter roles become blurred and this engenders conflict and confusion among family members. The most bewildered is the daughter who is at an age when her budding sexuality requires clear and reassuring guidance. The familiar father has suddenly put on the strange mask of lover. She never knows which role he will play at any given time. Her mother, too, becomes unpredictable. At one moment she is the usual caring parent, at another she sends subtle, suspicious messages that can only come from a rival. The girl's relationships with her siblings are also adversely affected as they become aware that she has a special hold on their father.

Of course, each family has its own unique cast of personalities and the dramatic twists and turns which they enact are of infinite variety. But the following composite case history describes a typical father-daughter incestuous situation and how the Criminal Justice System reacted before the CSATP was started and became effective. (Actual names are not used in this case history.)

Leslie is ten years old when her father begins his sexual advances. She has always been close to her dad. When he tentatively begins to fondle her, she finds the experience strange but

pleasurable. Slowly the sex play becomes more sophisticated as it progresses to mutual oral copulation and at puberty to intercourse. Their meetings which at first were excitingly secretive now become furtive and anxiety-ridden. Leslie is about to enter the difficult teenage years when the mounting tension within her becomes unbearable. Her father is now interfering unduly with her peer relations. She senses that his fatherly concern over boys who are paying her attention is tainted by jealousy. She no longer can tolerate body-contact with him and tries to resist, but he refuses to stop. Ashamed to confess the affair to her mother, she turns desperately to an adult friend who immediately calls the police.

Though the policeman tries to be kind, Leslie is frightened by the power and authority he represents. His probing questions are excruciatingly embarrassing. But an odd feeling of relief intermingled with exhilaration comes over her as she realizes that her secret has now been exposed and her father's power over her broken.

Her anxiety returns when she is brought to a children's shelter. Despite friendly attempts by attendants to make her stay pleasant, Leslie feels alone and threatened. This is the first time she has forcefully been separated from the family. She is overwhelmed by mixed emotions of fear, guilt and anger and convinced she will never be able to rejoin her family or face her friends and relatives. Since there is suspicion of inadequate protection by her mother, a foster home is found for her. But she will not adjust to the new family as this would confirm her fears that she has been banished from her own family. Though often told that she was the victim of the incestuous relationship, Leslie believes she is the one who is being punished. She enters a period of self-abusive behavior manifested variously through hostility, truancy, drug abuse and promiscuity.

Her father, Jim Wilson, a successful accountant, is in his mid-thirties when he becomes aware of deep boredom and disenchantment with his life. He feels stale-mated in his job and his prospects for advancement are poor. There is growing estrangement between himself and his wife. She no longer seems proud of him. In fact, most of her remarks concerning his ability as a provider, father or husband are critical and harassing. Their sexual encounters have no spark and serve only to relieve nervous tension. He fantasizes romantic liaisons with girls at work. But he has neither the skill nor courage to exploit his opportunities.

Jim finds himself giving increasing attention to Leslie. Of all his children, she has always been his favorite. She is always there for him, accompanies him on errands, snuggles close beside him as they spend hours together watching television. His wife has no interest in this pastime. At night she is either taking classes or studying with her classmates.

As Leslie cuddles beside him he becomes keenly aware of her warmth and softness. At times she wiggles on his lap sensuously somehow knowing that this gives him pleasure. He begins to caress her and "relives the delicious excitement of forbidden sex play during childhood," as one client expressed it. But this phase is soon engulfed by guilt feelings as the relationship gets out of hand and he finds himself making love to her as if she were a grown woman. Between episodes he chokes with self-disgust and vows to stop. But as if driven by unknown forces he continues to press his sexual attention on her. He now senses that she is trying to avoid him and no longer receptive to his advances. Though he doesn't use physical force, he relies on his authority as parent to get her to comply. He becomes increasingly suspicious of her outside activities and the seemingly continual stream of boys who keep coming to the house. With a sinking feeling he notices that she is beginning to respond to one of the boys. He cannot control the feeling of baleful jealously the boy evokes or his craven attempts to force his daughter to stop seeing him.

Jim's trance is suddenly shattered one evening as he returns home from work. A policeman emerges from the car parked in front of his home and advises him that he is under arrest. Numb with shame and fear, he is transported to the police station for questioning. Though informed of his constitutional rights, he finds himself making a fully detailed confession.

Jim is eventually convicted on a felony charge and given a jail sentence of one to five years. His savings are wiped out by the lawyer's fee of several thousand dollars. He finds imprisonment extremely painful. From a respected position in society he falls to the lowest social stratum. His fellow inmates call him a "baby-raper." No one is more despicable. He is segregated and often subjected to indignities and violence. His self-loathing is more intense than that of his inmates. He gradually finds some relief in the fervent resolution that, given the chance, he will more than make it up to his child, wife and family. A well-behaved inmate, he is released from jail in nine months. He has lost his job and after weeks of job-hunting, settles for a lower position. Jim faces an uncertain future with his wife and family.

The explosive reaction of the criminal justice system leaves Jim's wife, Liz, in shock and terror. She is certain that her family has been destroyed. There are subtle hints that she may have condoned the incestuous affair in the questioning by police and even others she once regarded as friends. She has failed both as wife and mother. Her feelings toward her daughter alternate between jealousy and motherly concern. Her emotional state vis-a-vis her mate is also ambivalent. At first Liz is blinded with disgust and hate at the cruel blow he had dealt her and vows to divorce him. Her friends and relatives insist this is her only recourse. But the rest of the children begin to miss him immediately and she realizes that on the whole, he has been a good father. Liz is also sharply reminded that he has been a

dependable provider as she faces the shameful task of applying for welfare. Nagging questions, however, continue to plague her. If she takes him back, what assurance does she have that he will not repeat the sexual offenses with her other daughters? Will her relatives and friends assume that she has deserted her daughter if she allows him to return home? Will the authorities ever permit her daughter and husband to live in the same home again? Is there any hope for their marriage?

It is evident that typical community intervention in incest cases, rather than being constructive, has the effect of a knock-out blow to a family already weakened by serious internal stresses.

I find it necessary to emphasize that the average family treated by the Child Sexual Abuse Treatment Program is not at all like the incestuous family described in the literature. Weinberg, for example, reported that 67% of the families he studied were in the low socio-economic bracket and that 64% of the incestuous fathers tested were below normal intelligence. He also noted that there was a disproportionate number of blacks in his sample (13).

The 300 families which have been referred to the Child Sexual Abuse Treatment Program constitute a fair cross section of Santa Clara County. The families are representative of the racial composition of the County which is 76.8% White, 17.5% Mexican-American, 3.0% Oriental, 1.7% Black, 1.0% Other. The makeup of the work force leans towards the professional, semi-professional and skilled blue collar. Average yearly income is $13,413 per household. The median educational level is 12.5 years.

THE CHILD SEXUAL ABUSE TREATMENT PROGRAM (CSATP)

In 1971, cases similar to the representative one described above, aroused the concern of Eunice Peterson, a supervisor of the Juvenile Probation Department. She conferred with Robert Spitzer, who was consulting psychiatrist to the Department at that time. Dr. Spitzer felt that family therapy would be a good first step towards constructive case-management of sexually abusive families. I was invited to undertake a pilot effort limited to ten hours of counseling per week for a ten-week period. Initial criteria were:

1. The clients would be counseled on-site at the Juvenile Probation Department.

2. The therapeutic approach would follow a "growth" model predicated on Humanistic Psychology.

3. Conjoint Family Therapy as developed by Virginia Satir (14) would be emphasized.

It was soon apparent that the new approach held high promise of meeting a critical problem of the community. The initial effort

expanded slowly due to meager funds. But the pressure of client needs was so strong that perpetuation of the new community resource was assured.

As the program got underway, I quickly discovered that conjoint family therapy alone was inadequate and, moreover, could not be usefully applied during early stages of the family's crisis. The fundamental aim of family therapy, to facilitate a harmonious familial system, was not discarded. It must be remembered, however, that incestuous families are badly fragmented as a result of the original dysfunctional family dynamics which are further exacerbated upon disclosure to civil authorities. The child, mother and father must be treated separately before family therapy becomes productive. Consequently, the treatment procedure was applied in this order: (a) individual counseling, particularly for the child, mother, and father; (b) mother-daughter counseling; (c) marital counseling, which becomes a key treatment if the family wishes to be reunited; (d) father-daughter counseling; (e) family counseling; and (f) group counseling. The treatments are not listed in order of importance, nor followed invariably in each case, but all are required for family reconstitution.

Another important finding during early phases of the program was that traditional counselor-client therapy, though important, was not sufficient. The reconstructive approach would be enhanced if the family were assisted in locating community resources for pressing needs such as housing, financial, legal, jobs, etc. This required close collaboration between the counselor and the Juvenile Probation Officer assigned to the case.

Still another development, which added immeasurably to program productivity, was the formation, in 1972, of the self-help group now known as Parents United. The insight that led to this step came when a mother of one of the first families treated was asked to make a telephone call to a mother caught in the early throes of the crisis. The ensuing conversation went on for over three hours and had a markedly calming effect on the new client. A week later, three of the more advanced mother clients met face-to-face for the first time and after a few meetings, to which several other women were invited, Parents United was formally designated and launched. The members meet weekly and after a brief conference to discuss progress in growth and effectivity, the members form various groups, i.e., a couple's group, an intense couples group size-limited to five pairs, a men's group, a women's group, and a mixed group. A separate organization, self-named Daughters United, composed of teenaged girls meets earlier in the evening.

Objectives of the CSATP

1. Provide immediate counseling and practical assistance to sexually abused children and their families, in particular to victims of father-daughter incest.

2. Hasten the process of reconstitution of the family and of the marriage, if possible, since children prosper best in normally functioning families headed by natural parents.

3. Marshall and coordinate all official services responsible for the sexually abused child and family, as well as private resources to ensure comprehensive case-management.

4. Employ a treatment model that fosters self-managed growth of individuals capable of positive contributions to society; rather than a medical model based on the vagaries of mental disease.

5. Facilitate expansion and autonomy of the self-help groups, initiated by the program, known as Parents United and Daughters United; provide guidance to the membership, such as (a) training in co-counseling, self-management, and intra-family communication and (b) in locating community resources, i.e., medical, legal, financial, educational, etc.

6. Inform the public at large and professional agencies about the existence and supportive approach of the program, especially to encourage sexually-abusive families to seek the services of the program voluntarily.

7. Develop informational and training material to enable emulation or adaptation of the CSATP model by other communities.

TREATMENT MODEL

The therapeutic approach of the CSATP is based on the theory and methods of Humanistic Psychology, in particular the relatively new incorporation by the field of the discipline known as Psychosynthesis, founded by Roberto Assagioli (15). Other seminal writers of importance to the CSATP are Carl Rogers, Abraham H. Maslow, Virginia Satir, Frederick Perls, Haridas Chaudhuri, and Eric Berne.

Assagioli agrees that many similarities exist between Psychosynthesis and existentialist/humanistic views. Principal similarities are: (a) the method of starting from within, experiencing self identity; (b) the concept of personal growth; (c) the importance of the meaning which a person makes of his life; (d) the key notion of responsibility and ability to decide among alternatives; (e) the emphasis on present and future rather than regrets or yearnings for the past; and (f) the recognition of the uniqueness of each individual. But in addition Assagioli stresses: (a) the will as an essential function of self; (b) the experience of self-awareness independent of immediate I-consciousness of the various parts of ourselves; (c) a positive, optimistic view of the human condition; and (d) systematic use of didactic and experiential techniques which follow an individuated plan for psychosynthesis, the harmonious blending of mind, body and spirit around the unifying essence, the self (16).

A central notion in the treatment model is the building of social responsibility, the realization that each of us is an important element of society. We must actively participate in the development of social attitudes and laws or be helplessly controlled by them. Chaudhuri gives firm emphasis to this imperative: "Since psyche and society are essentially inseparable, one has to take into account the demands of society.... One may criticize society or try to remold it. But one cannot ignore society or discard it." (17)

Major Premises

1. The family is viewed as an organic system. Family members assume behavior patterns to maintain system balance (family homeostasis).

2. A distorted family homeostasis is evidenced by psychological/physiological symptoms in family members.

3. Incestuous behavior is one of the many symptoms possible in troubled families.

4. The marital relationship is a key factor in family organic balance and development.

5. Incestuous behavior is not likely to occur when parents enjoy mutually beneficial relations.

6. A high self-concept in each of the mates is a prerequisite for a healthy marital relationship.

7. High self-concepts in the parents help to engender high self-concepts in the children.

8. Individuals with high self-concepts are not apt to engage others in hostile-aggressive behavior. In particular, they do not undermine the self-concept of their mates or children through incestuous behavior.

9. Individuals with low self-concepts are usually angry, disillusioned and feel they have little to lose. They are primed for behavior that is destructive to others and to themselves.

10. When such individuals are punished in the depersonalized manner of institutions, the low self-concept/high destructive energy syndrome is reinforced. Even when punishment serves to frustrate one type of hostile conduct, the destructive energy is diverted to another outlet or turned inward.

Productive case-management of the molested child and her family calls for procedures that alleviate the emotional stresses of the experience and of punitive action by the community; enhance the processes of self-awareness and self-management; promote family unity and growth, and a sense of responsibility to society. The purpose is not to extinguish or modify dysfunctional behavior by

external devices. Rather, we try to help each client develop the habit of self-awareness (the foundation for self-esteem) and the ability to direct one's own behavior and life-style.

Method

It is necessary to generate a warm, optimistic atmosphere before productive therapeutic transactions can ensue with families that have broken the incest taboo. They must be given hope, reassured that their situation is not as singular or as disabling as they have been led to believe. Feelings of despair, shame and guilt must be listened to with compassion, as natural expressions of inner states. Awareness and acceptance of current feelings, without evaluation, allows the clients to assimilate them and to move on with their lives. I know that I must continually work at developing this attitude within myself.

When I met my first family, it was easy to maintain an attitude of acceptance with the child and her mother. But in preparing myself for the session with the father, I read the lurid details of his sexual activities with his daughter which included mutual oral copulation and sodomy at the age of ten. The compassionate, therapeutic attitude which I can now write about so freely and perhaps pompously, completely dissipated. I was forced to go into deep exploration of my unconscious for its own incestuous impulses and found that my early religious upbringing had done its repressive work thoroughly.

After confronting the revulsion and anger that I was projecting on my client, I was able to assume a reasonable therapeutic mien. When I actually met with my client, my problem was much less difficult than I had anticipated. The raw feelings of despair and confusion needed to be attended to and my own hangups became less intrusive.

I cannot over-emphasize the importance of self-work on the part of the therapist. This is the central theme of workshops I conduct for individuals who want to help incestuous families.

Self-Assessment and Confrontation

Once a working relationship has been established and the highly charged emotional climate subsides, the clients begin to take an inventory of personal and family characteristics. Initially, during this exploration, I underscore the positive traits. What does the girl, for example, like about herself? What does she appreciate in other family members and the family as a whole? Before she can be motivated to work actively for personal and family growth, she must be convinced that she and the family are worth the effort. From this positive stance, the clients can then proceed to identify weaknesses and maladaptive habits that need to be improved or eliminated. These might include uncontrolled use of drugs, food, alcohol, and cigarettes; hostile-aggressive behavior that interferes with progress in family, school and work relations; sexual promiscuity; inconsistent study

and work habits; and typically, the inability to communicate effectively, especially with important persons in their lives.

As the clients gain confidence in their search for self-knowledge, they begin to probe the painful areas connected with the incest. In what may be termed a confrontation-assimilation process, I encourage the child, father and mother as well as other family members to face and express the feelings associated with the incestuous experience. It is indicated that buried feelings (fear, guilt, shame, anger, etc) if not confronted, will return as ghosts to harass them. The feelings cannot be denied; they will have their effect somehow. If confronted now, they will lose their power to hurt them in the future. With some clients, the pain-provoking memories can be dealt with fairly early in the therapy; with others I find it prudent to proceed more slowly.

Although I listen with compassion and understanding to the father's feelings, I will in no way condone the incestuous conduct or go along with pleas for mercy, such as, that he is cursed and forced into incest by evil forces, or that he suffers from an exotic mental disease. He eventually is induced to admit the bald fact that he was totally responsible for the incestuous advances to his daughter. No matter the extenuating circumstances, including possible provocative behavior by his daughter, his actions betrayed his child and wife and their reliance on him as father and husband. Personal responsibility for the incestuous behavior is often objectively acknowledged by the men during group therapy and in sessions with their wives and daughters.

As a general rule, the mother will admit eventually that she was party to the incestuous situation and must have contributed to the underlying causes. Certainly, something must have been awry in her relationships with her husband and daughter. In order to relieve the daughter of feelings of self-blame and guilt for endangering the family, she is firmly told by her mother and as soon as possible by her father, that she was the victim of poor parenting. This step is also important for regaining her trust in her father and mother as parents. In time, however, she will confide she was not entirely a helpless victim and is gently encouraged to explore this self-revelation.

Up to this point, the therapeutic approach is similar to that used by many humanist psychologists, particularly those of the Gestalt school (18). The major objectives of these first steps is to bring to awareness certain conscious and unconscious components of the individual personalities, as well as those that comprise the "personality" of the family. An important feature of the treatment is deliberate coaching in the techniques of self-awareness so that each individual can develop independently the skill of observing his/her own growth process and that of the family.

Self-Identification

The last two phases of the treatment program draw on the writings of Dr. Assagioli and others in the field of Psychosynthesis. A key notion during the later phases is that the self is a unique entity that is more than the changing functions of mind, body, and spirit. A strong sense of self-identity must be internalized by an individual before he can experience self-esteem. Developing this line of thought, the counselor points out that the self in each family member is a relatively stable center that is more than the roles each plays as daughter, student, mother, wife, father, husband, or worker; more than the transient feelings of hostility, guilt, shame, etc.; more than the changing body states of pain and disease. Further, it is indicated that the marriage and the family also have integrating centers that are more than the daily drama enacted by the principals.

Self-Management

Once the idea of the self is entrenched and distinguished from the changing elements of personality, the concept of self-management is introduced. The assumption is that everyone can learn to control the way he/she behaves and ultimately the course his/her life will take. Each person in the family can behave purposefully to realize his potential and move deliberately toward self-actualization. The marriage and the family, conceptualized as separate organisms, can also be given purposeful direction. A major milestone is reached when the client acknowledges that all his past and current experiences are available to him for personal growth. He will assimilate all experiences, disown none.

A particular psychological school or discipline is not rigidly adhered to in attempting to satisfy the aims of the therapeutic model. Though the model roughly falls under the umbrella of Humanistic Psychology, other theories and methods, such as the psychoanalytic or the behavioral, are not denigrated or dismissed a priori.

To avoid a mechanical, step-by-step approach, the last three phases of the therapeutic program are not developed in strict sequence. After initial efforts to bring about a good working relationship, I use an iterative strategy in guiding the client through the concepts and processes of self-assessment, self-identification, and self-management. They are developed more in parallel than in serial fashion. A variety of techniques are employed in implementing the therapeutic model. None is used for its own sake; instead, I try to tune into the client and the situation and try to apply a fitting technique. In most instances, experiential techniques are called upon that elicit affective responses; however, cognitive and spiritual needs are not neglected. When indicated, I will briefly discuss the strategy and progress of the therapy and answer questions from the client. Certain clients who begin to internalize and practice the techniques at home report profound spiritual experiences. These clients are given special exercises that help them to expand and integrate the spiritual awakening.

Principal sources of the techniques come from Psychosynthesis, Gestalt therapy, conjoint therapy, psychodrama, Transactional Analysis, and personal journal keeping. To maintain continuity, exercises that can be done at home or at work between meetings are given to the client. Many of the techniques are described in detail in a previous article (19).

PRELIMINARY RESULTS AND MILESTONES

1. No recidivism reported in the more than 250 families receiving a minimum of ten hours of treatment, and formally terminated.

2. Compared to pre-program outcomes, the integrated, compassionate approach indicates that:

(a) The children are returned to their families sooner; 90% within the first month, 95% eventually.

(b) The self-abusive behavior of the children, usually amplified after exposure of the incestual situation, has been reduced both in intensity and duration.

(c) More marriages have been saved (about 90%); many confiding that their relationships are even better than they were before the crisis.

(d) The offender's rehabilitation is accelerated since the counseling program is started soon after his arrest and continues during and after incarceration. Previous to the CSATP, individual and marriage counseling, if any, occurred after release from jail.

(e) In father-daughter incest, the difficult problem of re-establishing a normal relationship is more often resolved and in less time.

3. Parents United has grown from three mother-members to about sixty members, of which half are father-offenders. Daughters United, comprised of teenaged victims of incest, has also grown substantially. Both groups are becoming increasingly self-sufficient; several of the older members act as group co-leaders.

4. In addition to self-help benefits, the Parents United formula is proving to members that they can become a strong voice in the community; a significant realization to those members who used to regard themselves as the pawns of civil authorities.

5. Offenders, who formerly would have received long jail or prison sentences, are now given suspended sentences or shorter terms due to increasing recognition of the CSATP by the judiciary as an effective alternative to incarceration.

6. The difficult goal of mobilizing typically disjointed and often competitive services into cooperative efforts is gradually being reached.

7. Due to the public education work, the referral rate has increased to about 180 families annually; about 60% of the referrals come from agencies other than the Police or Juvenile Probation Departments, or directly from people heretofore fearful of reporting the problem.

8. The CSATP is receiving nation-wide coverage by the media. Staff members and, more importantly, members of Parents United have appeared on several television and radio programs; the CSATP has been the subject of numerous newspaper and magazine articles.

9. Hundreds of informational packets have been sent to requestors throughout the country to abet the aim of having the CSATP serve as a model for other communities.

10. Several presentations and training seminars are conducted each year for professional groups by the writer and staff members. The presentations now include mothers, daughters, and fathers of the families treated for incest who are willing to answer questions from the audience, a significant breakthrough.

11. The CSATP is involving many volunteers and graduate students who make valuable contributions while being trained.

The Children's Division of the American Humane Association, in Denver, Colorado, organized for the protection of abused, neglected, and sexually exploited children, has advised the CSATP that it is the only endeavor in this country that takes a comprehensive supportive position in the treatment of sexually abused children and their families. The CSATP is unique also in that it constitutes the only substantive attempt extant to apply the principles and methods of Humanistic Psychology to a serious psychosocial problem. Possibly the most encouraging recognition and constructive endorsement of the CSATP was accorded recently by a bill introduced by Assemblyman John Vasconcellos, Santa Clara County, to the 1975-76 Session of the California Legislature. The bill (AB2288) is intended to provide funds for establishing a demonstration center for the treatment of child sexual abuse on the CSATP approach. The bill served as a call-to-action for members of Parents United as well as a number of concerned professionals. Many went to the State Capital, Sacramento, to lobby for its passage. The bill was approved by a vote of 68 to 1 by the Assembly, unanimously by the Senate, and finally signed into law by Governor Brown.

DISCUSSION

Current attitudes and laws regarding incest are myth-ridden and ineffective. Society is not attending responsibly to a problem vital to its own survival. The impact of civic authorities on incestuous families, particularly those in which the father is the offender, commonly adds up to either rejection of the victim's plea for help or disruptive punishment of the entire family.

I do not suggest that criminal laws in support of the incest taboo should be abolished and offenders should be dealt with exclusively by mental health workers. Reliance on the weekly therapeutic hour alone had not proven successful for several families who eventually came to the CSATP. Typically, the mother had become aware that her husband was sexually exploiting their daughter and threatened to break up the marriage if he did not obtain psychiatric treatment. The offender complied but stopped going to the therapist after a few sessions. A month or two later he resumed the sexual abuse of his daughter. In two instances the father continued his offenses while undergoing treatment. The motivating drive and/or therapy alone were not sufficient and the troubled family was left with its problem.

In five other cases in which punishment alone was employed, the deterrent effect hoped for proved equally inadequate. After serving long sentences, the five men came to the attention of the CSATP for repeating the offense with other daughters or stepdaughters.

The CSATP works closely with the Criminal Justice System of Santa Clara County and other local counties. We do not delude ourselves that the promising results which are coming to light would have occurred without the cooperation of the Police, Probation Officers and the Courts. The Police and Probation Departments are major referral sources. A distraught victim, mother, or friend will usually turn to the Police for immediate help since they are available 24 hours a day. It is now a common practice for officers who investigate the cases to refer offenders and their families to the CSATP.

For the offender the implication is that involvement in the CSATP is likely to be strongly considered by the judge and prosecuting attorney during court proceedings. His own lawyer will also urge him to join the CSATP. Though all offenders hope that the penalty will be softened by participation in the CSATP, many find it equally compelling to do so for the aid the program gives to their families. Usually each man soon realizes that the program will help him understand and control his deviant impulses and to reestablish sound relationships with his wife, the daughter he victimized, and the other children.

In all cases the authority of the Criminal Justice System, and the court process, seems necessary in order to satisfy what may be termed an expiatory factor in the treatment of the offender and his family. It appears that the offender needs to know unequivocally that the community will not condone his incestuous behavior and that he must face the consequences. The victim and her mother also admit to deriving comfort from knowledge of the community's clear stand on incest. All family members, however, will do their best to frustrate the system if they anticipate that the punishment will be so severe that the family will be destroyed; that they, in turn, will become "victims" of the Criminal Justice System, including the child-victim herself.

No matter what the reasons may be for admission of an incestuous family into the CSATP, it is our responsibility to help the family reconstitute itself as quickly as possible, hopefully around the original nuclear pair. Even if the offender comes to the CSATP only for the purpose of saving his skin, it is up to us to show him that he can reap more substantial benefits for himself and his family from honest participation in the CSATP.

Of course, the CSATP is not equally effective with all clients. About ten percent of referrals will elude our efforts. They will either not come in for the initial interview or drop out soon after treatment has begun. Four couples were dismissed from the program because the father and/or his wife would not admit culpability and placed the blame entirely on the child-victim and her seductive behavior. In these instances, extraordinary effort was required in the treatment of the deserted child. Three of the girls, after many attempts, successfully adjusted to foster homes. They are now married and apparently doing well.

The CSATP is a growing community resource. Some of its objectives have only partly been achieved; others will be added, dropped, or modified. But there is at least the beginning here of a response to Vincent de Francis' clarion call to the American community to protect the sexually molested child (20). Moreover, the CSATP complies with Besharov's request for enlightened intervention that considers the requirements of the entire family, the parents as well as the children (21).

By working integrally with the Criminal Justice System the CSATP shows promise of developing into a model for other American communities. Each community must be given the opportunity to treat incestuous families in a manner that is neither permissive nor cruelly punitive. A national position must be taken on the incest taboo and laws enacted that are effective and consistent. The community must publicize these statutes and the penalties for violating them. To prevent incest the public must be educated to become aware of predisposing conditions and to take appropriate action. Finally, comprehensive procedures similar to the CSATP must be established in each community to treat sexually-abused children and their families to enhance their chances for reconstitution and to prevent future violations.

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APPENDIX A

MONTANA LAWS RELATING TO ABUSED, NEGLECTED AND DEPENDENT CHILDREN OR YOUTH

(Prepared and printed by the State Department of Social and Rehabilitation Services, Community Services Division, Social Services Bureau, P. O. Box 4210, Helena, MT 59601)

Montana Laws relating to abused, neglected and dependent children or youth continued:

Section 10-1300 through 10-1322, R.C.M., 1947:

10-1300. Declaration of policy: It is hereby declared to be the policy of the state of Montana:

(1) to insure that all youth are afforded an adequate physical and emotional environment to promote normal development;

(2) to compel in proper cases the parent or guardian of a youth to perform the moral and legal duty owed to the youth;

(3) to achieve these purposes in a family environment whenever possible; and

(4) to preserve the unity and welfare of the family whenever possible.

10-1301. Definitions. (1) "Child" or "youth", for purposes of this law, means any person under eighteen (18) years of age.

(2) "Abuse" or "neglect" means:

(a) the commission or omission of any act or acts which materially affect the normal physical or emotional development of a youth. Any excessive physical injury, sexual assault, or failure to thrive, taking into account the age and medical history of the youth, shall be presumed to be non-accidental and to "materially affect" the normal development of the youth.

(b) the commission or omission of any act or acts by any person in the status of parent, guardian, or custodian who thereby and by reason of physical or mental incapacity or other cause, refuses or, with state and private aid and assistance is unable, to discharge the duties and responsibilities for proper and necessary subsistence, education, medical, or any other care necessary for the youth's physical, moral, and emotional well-being.

(3) "Dependent youth" means a youth who is abandoned, dependent upon the public for support, destitute, without parents or guardian or under the care and supervision of a suitable adult, or who has no proper guidance to provide for his necessary physical, moral, and emotional well-being. A child may be considered dependent and legal custody transferred to a licensed agency if the parent or parents voluntarily relinquish custody of the child.

(4) "Youth in need of care" means a youth who is dependent or is suffering from abuse or neglect within the meaning of this act.

10-1302. Jurisdiction and venue. (1) In all matters arising under this act, the youth court shall have concurrent jurisdiction with the district courts over all youths who are within the state of Montana for any purpose, or any youth or other person subject to this act who under a temporary or permanent order of the court has voluntarily or involuntarily removed himself from the state or the jurisdiction of the court, or any person who is alleged to have abused, neglected or caused the dependency of a youth who is in the state of Montana for any purpose.

(2) Venue shall be determined pursuant to section 10-1207, R.C.M., 1947.

10-1303. Declaration of policy (reporting). It is the policy of this state to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. It is intended that the mandatory reporting of such cases by professional people and other community members to the appropriate authority will cause the protective services of the state to seek to prevent further abuses, protect and enhance the welfare of these children, and preserve family life wherever possible.

History: En. Sec. 1, Ch. 178, L. 1965; amd. Sec. 1, Ch. 292, L. 1973.

10-1304. Reports. Any physician who examines, attends or treats a person under the age of majority, or any nurse, teacher, social worker, attorney, or law enforcement officer or any other person who has reason to believe that a child has had serious injury or injuries inflicted upon him or her as a result of abuse or neglect, or has been willfully neglected, shall report the matter promptly to the department of social and rehabilitation services, its local affiliate, and the county attorney of the county where the child resides. This report shall contain the names and addresses of the child and his or her parents or other persons responsible for his or her care; to the extent known, the child's age, the nature and extent of the child's injuries, including any evidence of

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previous injuries, and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries or showing the willful neglect and the identity of person or persons responsible therefor; and the facts which led the person reporting to believe that the child has suffered injury or injuries, or willful neglect, within the meaning of this law.

History: En. Sec. 2, Ch. 178, L. 1965; amd. Sec. 2, Ch. 292, L. 1973.

10-1305. Action on reporting. If from said report it shall appear that the child suffered such injury or injuries or willful neglect, the social worker shall conduct a thorough investigation into the home of the child involved and into the circumstances surrounding the injury of the child and into all other matters which, in the discretion of the social worker, shall be relevant and material to the investigation. If from the investigation it shall appear that the child suffered such injury or injuries or willful neglect, the department shall provide protective services to protect the child and preserve the family. The department will advise the county attorney of its investigation.

The investigating social worker shall also furnish a written report to the department of social and rehabilitation services who shall have the responsibility of maintaining a central registry on child abuse or willful neglect cases.

History: En. Sec. 3, Ch. 178, L. 1965; amd. Sec. 3, Ch. 292, L. 1973.

10-1306. Immunity from liability. Anyone participating in the making of a report pursuant to the provisions of this act or participating in (a) judicial proceedings resulting therefrom shall be presumed to be acting in good faith and in so doing shall be immune from any liability, civil or criminal, that might otherwise be incurred or imposed, unless the person acted in bad faith or with malicious purpose.

History: en. Sec. 4, Ch. 178, L. 1965.

10-1307. Admissibility of evidence. In any proceeding resulting from a report made pursuant to the provisions of this law or in any proceeding where such a report or any contents thereof are sought to be introduced into evidence, such report or contents thereof or any other fact or facts related thereto or to the condition

of the child who is the subject of the report shall not be excluded on the ground that the matter is or may be the subject of a physician-patient privilege or similar privilege or rule against disclosure.

History: En. Sec. 5, Ch. 178, L. 1965.

10-1308. Confidentiality. The case records of the department of social and rehabilitation services, its local affiliate, the county welfare department, the county attorney and the court concerning actions taken under this act shall be kept confidential unless the court determines that they should be released.

10-1309. Emergency protective service. (1) Any social worker of the department of social and rehabilitation services, the county welfare department, a peace officer, or county attorney who has reason to believe any youth is in immediate or apparent danger of violence or serious injury may immediately remove the youth and place him in a protective facility. The department may make a request for further assistance from the law enforcement agency or take such legal action as may be appropriate.

(2) A petition shall be filed within forty-eight (48) hours of emergency placement of a child unless arrangements acceptable to the agency for the care of the child have been made by the parents.

(3) The department of social and rehabilitation services and the county welfare department shall comply with the procedure set forth in section 10-1305, R.C.M. 1947.

(4) The department of social and rehabilitation services and the county welfare department shall make such necessary arrangements for the youth's well-being as are required prior to the court hearing.

10-1310. Petitions. (1) The county attorney shall be responsible for filing all petitions alleging abuse, neglect or dependency. He may require all state, county, and municipal agencies, including law enforcement agencies, to conduct such investigations and furnish such reports as may be necessary.

(2) Such petitions shall be given preference by the court in setting hearing dates.

(3) A petition alleging abuse, neglect, or dependency, is a civil action brought in the name of the state of Montana. The rules of civil procedure shall apply except as

herein modified. Proceedings under a petition are not a bar to criminal prosecution.

(4) The parents or parent, guardian, or other persons or agency having legal custody of the youth named in the petition, if residing in the state, shall be served personally with a copy of the petition, and summons at least 5 days prior to the date set for hearing. If such person or agency resides out of state or is not found within the state, the rules of civil procedure relating to service of process in such cases shall apply.

(5) In the event service cannot be made upon the parents or parent, guardian, or other person or agency having legal custody, the court shall appoint an attorney to represent the unavailable party where in the opinion of the court the interests of justice require.

(6) If a parent of the child is a minor, notice shall be given to the minor parent's parent or guardian, and if there is no guardian the court shall appoint one.

(7) Any person interested in any cause under this act has the right to appear.

(8) Except where the proceeding is instituted or commenced by a representative of the department of social and rehabilitation services, a citation shall be issued and served upon a representative of the department of social and rehabilitation services, prior to the court hearing.

(9) The Petition shall:

(a) state the nature of the alleged abuse, neglect, or dependency;

(b) state the full name, age, and address of the youth, and the name and address of his parents or guardian or person having legal custody of the youth;

(c) state the names, addresses, and relationship to the youth of all persons who are necessary parties to the action.

(10) The petition may ask for the following relief:

(a) temporary investigative authority and protective services;

(b) temporary legal custody;

(c) limited legal custody;

(d) permanent legal custody, including the right to consent to adoption;

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(e) appointment of guardian ad litem;

(f) any combination of the above or such other relief as may be required for the best interest of the youth.

(11) The petition may be modified for different relief at any time within the discretion of the court.

(12) The court may at any time on its own motion or the motion of any party appoint a guardian ad litem for the youth or counsel for any indigent party.

(13) This section does not apply to a petition for temporary investigative authority and protective services.

10-1311. Petition for temporary investigative authority and protective services.

(1) In cases where it appears that a youth is abused or neglected or is in danger of being abused or neglected, the county attorney may file a petition for temporary investigative authority and protective services.

(2) A petition for temporary investigative authority and protective services shall state the specific authority requested and the facts establishing probable cause that a youth is abused or neglected or is in danger of being abused or neglected.

(3) The petition for temporary investigative authority and protective services shall be supported by an affidavit signed by the county attorney or a department of social and rehabilitation services report stating in detail the facts upon which the request is based.

(4) (a) Upon the filing of a petition for temporary investigative authority and protective services, the court may issue an order granting such relief as may be required for the immediate protection of the youth.

(b) The order shall be served by a peace officer or a representative of the department of social and rehabilitation services on the person or persons named therein.

(c) The order shall require the person served to comply immediately with the terms thereof or, upon failure to so comply, to appear before the Court

issuing the order on the date specified and show cause why he has not complied with the order. Except as otherwise provided herein, the rules of civil procedure shall apply.

(d) Upon a failure to comply or show cause the court may hold the person in contempt or place temporary legal custody of the youth with the department of social and rehabilitation services until further order.

(5) The court may grant the following kinds of relief:

(a) Right of entry by a peace officer or department of social and rehabilitation services worker;

(b) Medical and psychological evaluation of youth or parents, guardians, or person having legal custody;

(c) Require the youth, parents, guardians, or person having legal custody to receive counseling services:

(d) Place the youth in temporary medical facility or facility for protection of the youth;

(e) Require the parents, guardian, or other person having custody to furnish such services as the court may designate;

(f) Such other temporary disposition as may be required in the best interest of the youth.

10-1312. Hearing. (1) In a hearing on a petition under section 10-1310, R.C.M., 1947, the court shall determine whether said youth is an abused, neglected or dependent child, and ascertain, as far as possible, the cause thereof.

(2) The court shall hear evidence regarding the residence of the child, whereabouts of the parents, guardian or nearest adult relative, the financial ability of any such parents,to pay the cost of care of the child, whether or how long the child has been maintained in whole or in part by public or private charity, and may take into consideration the report of the county welfare department filed with the clerk of the court, pursuant to section 10-1313, R.C.M. 1947.

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(3) In all civil and criminal proceedings relating to abuse, neglect or dependency the doctor-patient privilege and husband-wife privilege shall not apply to the extent any testimony relates to such matters.

10-1313. Investigation of parents' financial ability. Whenever any petition is filed with the clerk of the district court alleging abuse, neglect or dependency, the clerk of such court shall immediately deliver to the county welfare department of the county in which the petition is filed, a copy of the petition with a notation thereon giving the day and time fixed by the court for hearing the petition. Upon receipt of such copy of petition the county welfare department shall make an investigation for the purpose of ascertaining whether the parent or parents, if any, of the child live within the county and the financial ability of such parent or parents, if any, to pay the cost of supporting the child in a foster home, and shall file with the clerk of such court, before the time fixed for the hearing, a written report of such investigation. If, upon hearing, the court finds and determines that the child has parents, or a parent, who is financially able to pay a part or the whole of such cost, and the child is ordered placed in a foster home, the court shall make an order requiring such parents, or parent, to pay such amount as the court may deem proper. A copy of the written report shall be provided to all parties to the proceeding before the time filed for hearing.

If the child is placed in a foster home, the state department of social and rehabilitation services shall pay one-half (½) of the cost thereof, and the county in which such child has residence shall pay the other one-half (½) thereof. Any amount collected from a parent or parents, when a child is placed in a foster home, shall be transmitted to the state department of social and rehabilitation services. The department shall then pay to the county one-half (½) of the amount so collected.

10-1314. Judgement. (1) If a youth is found to be abused, neglected, or dependent, the court may enter its judgement making any of the following dispositions to protect the welfare of the youth:

(a) permit the youth to remain with his parents or guardian subject to those

conditions and limitations the court may prescribe;

(b) transfer legal custody to any of the following;

(i) department of social and rehabilitation services;

(ii) a child-placing agency willing and able to assume responsibility for the education, care and maintenance of the youth and which is licensed or otherwise authorized by law to receive and provide care of the youth; or

(iii) a relative or other individual who, after study by a social service agency designated by the court, is found by the court to be qualified to receive and care for the youth;

(c) order any party to the action to do what is necessary to give effect to the final disposition, including undertaking medical and psychological evaluations, treatment and counseling;

(d) order such further care and treatment as the court may deem in the best interest of the youth.

(2) Whenever the court vests legal custody in any agency, institution or department it shall transmit with the dispositional judgement copies of any medical report, and such other clinical, predisposition or other reports and information as may be pertinent to the care and treatment of the youth.

(3) Any youth found to be abused, neglected or dependent may be committed to the Montana children's center, and if the center is unable to receive the child, or if, for any other reason, it appears to be in the best interest of the child, the court may make such other disposition of the child as the court deems best for his social and physical welfare. The form of commitment shall be as follows:

ORDER OF COMMITMENT

State of Montana, County of .....ss:

In the District Court of the .....Judicial District.

On the .... day of ....., 19 ...., ... minor of this county, was charged on the petition of ....., of county attorney of

.....county, with being an abused or neglected or dependent child. Upon due proof I find that it is for the best interests of the child that he be taken from the custody of his parents, guardian or other person having custody of him.

The names, addresses and occupations of the parents are:

Name	Address	Occupation
.....	.....	.....
.....	.....	.....

The child's guardian is ..... The child is in the costody of ..... It is ordered that ..... be committed to ..... until discharged as provided by law.

Witness my hand this ..... day of ..... A.D. 19....

.....

Judge

(4) Transfer of legal custody of a child shall include guardianship of any assets or estate of the child, unless otherwise specified by the court.

(5) Except in cases in which the court permanently terminates all parental rights or rights of the guardian of the youth, the court shall retain jurisdiction over the case and may subsequently modify any disposition ordered pursuant to this section.

10-1315. The department of social and rehabilitation services and the county welfare department shall have the primary responsibility to provide the protective services authorized by this act and shall have the authority pursuant to this act to take temporary, limited or permanent custody of a child when ordered to do so by the court, including the right to give consent to adoption.

10-1316. Foster or boarding home operator defined. Any person owning or operating a home or institution into which home or institution he takes any child or children for the purpose of caring for them and maintaining them and for which care and maintenance he receives money or other consideration of value and which child is neither his son, daughter, ward, nor related to him by blood, shall be deemed to be an "operator" of a "foster home or boarding home" within the meeting of this act, except that this act,

shall not apply when a person accepts such care and custody of such child on a temporary basis and simply as a temporary accomodation for the parent or parents, guardian or relative of such child. The word "person" where used in this act, shall include any individual, partnership, voluntary association or corporation.

History: En. Sec. 1, Ch. 178, L. 1947.

10-1317. License required. No person shall maintain or operate a fostor or boarding home for any child or children within the meaning of this act without first securing a license in writing from the division of child welfare services of the state department of public welfare. No fee shall be charged for such license.

History: En. Sec. 2, Ch. 178, L. 1947.

10-1318. Issuance of License - Authority of issuing agency. The division of child welfare services to the state department of public welfare is hereby authorized to issue licenses to persons conducting boarding or foster homes and to prescribe the conditions upon which such licenses shall be issued, and making such rules and regulations as it may deem advisable for the operation and regulation of foster and boarding homes for minor children consistent with the welfare of such children. Such licensing agency shall have the power and authority to inspect all such licensed foster and boarding homes through its duly authorized representative and to cancel licenses theretofore issued for the failure to observe such rules and regulations. The person operating such homes shall give to such representative such information as may be required and afford them every reasonable facility for observing the operation of such homes.

History: En. Sec. 3, Ch. 178, L. 1947.

10-1319. Penalty. Any person who maintains or conducts a foster or boarding home, or assists in conducting or maintaining such home without having first obtained a license in writing as hereto provided, shall be guilty of a misdemeanor and upon conviction be punished by a fine not to exceed one hundred dollars ($100.00).

History: En. Sec. 4, Ch. 178, L. 1947.

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10-1320. Payment for support of dependent and neglected children -- reimbursement by county. (1) Whenever agreements are entered into by the department of social and rehabilitation services for placing dependent and neglected children in approved family foster homes or licensed private institutions, the department shall pay by its check or draft each month from any funds appropriated for that purpose the entire amount agreed upon for board, clothing, personal needs, and room of such children.

(2) On or before the 20th of each month the department shall present a claim to the county of residence of such children for one-half the payments so made during the month. The county must make reimbursement to the department within 20 days after such claim is presented.

History: En. Sec. 1, Ch. 48, L. 1949, amd. Sec. 1, Ch. 194, L. 1965.

10-1321. Recovery from parents - division between state and county. In the event any recovery is made from the parent or parents of children for whom board and room has been paid by the state and county any amount so recovered shall be divided equally between the state department and the county of residence of such child or children.

History: En. Sec. 2, Ch. 48, L. 1949.

10-1322. Punishment of parents and other adults. (1) If the evidence indicates violation of the criminal code, it shall be the responsibility of the county attorney to file appropriate charges against the alleged offender.

(2) District court shall have original jurisdiction under this section.

10-1207. Venue and Transfer. (1) The county where a youth is a resident has initial jurisdiction over any youth alleged to be a delinquent youth; a youth in need of supervision; or a youth in need of care, and the youth court of that county shall assume the initial handling of the case. Transfers of venue may be made to any of the following counties in the state:

(a) The county in which the youth is apprehended or found;

(b) The county in which the youth is alleged to have violated the law;

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(c) The county of residence of the youth's parents or guardian.

(2) A change of venue may be ordered at any time by the concurrence of the youth court judges of both counties in order to assure a fair, impartial and speedy hearing and final disposition of the case.

(3) In the case of a youth sixteen (16) years of age or older who is accused of one of the serious offenses listed in Section 10-1229, the court in the county where the offense occurred shall serve as a transfer hearing court, and if the youth is to be tried in district court, the charge shall be filed and trial held in the district court of the county where the offense occurred.